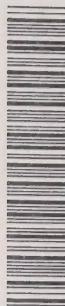


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Ontario

ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

P.S.A. Lamek, Q.C.

E.A. Cronk

Thomas Millar

Commissioner

Counsel

Associate Counsel

Administrator

Transcript of evidence
for
September 8, 1983

VOLUME 30

OFFICIAL COURT REPORTERS

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14 Carlton Street, 7th Floor,
Toronto, Ontario M5B 1J2

595-1065

Freedom X
- Scott
- Orved
- Percival
- Forder
- Hunt
- Sykes.



ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN
AND RELATED MATTERS.

Hearing held on the 8th Floor,
130 Dundas Street West, Toronto,
Ontario, on Thursday, the 8th
day of September, 1983.

- - - - -

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
THOMAS MILLAR - Administrator
MURRAY R. ELLIOT - Registrar

- - - - -

APPEARANCES:

| | |
|----------------------|---------------------------------|
| P.S.A. LAMEK, Q.C.) | Commission Counsel |
| E. CRONK) | |
| T.C. MARSHALL, Q.C.) | Counsel for the Attorney- |
| D. HUNT) | General and Solicitor |
| | General of Ontario (Crown |
| | Attorneys and Coroner's Office) |
| I.G. SCOTT, Q.C.) | Counsel for The Hospital |
| I.J. ROLAND) | for Sick Children |
| R. BATTY) | |
| M. THOMSON) | |
| B. PERCIVAL, Q.C. | Counsel for The Metropolitan |
| | Toronto Police |
| W.N. ORTVED | Counsel for numerous Doctors |
| | at The Hospital for Sick |
| | Children |
| B. SYMES | Counsel for the Registered |
| | Nurses' Association of Ontario |
| | and 35 Registered Nurses at |
| | The Hospital for Sick Children |

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APPEARANCES: (Continued)

| | |
|------------|---|
| D. BROWN | Counsel for Susan Nelles - Nurse |
| E. FORSTER | Counsel for Phyllis Trayner - Nurse |
| J.A. OLAH | Counsel for Janet Brownless - R.N.A. |

VOLUME 30




INDEX OF WITNESSES

| <u>NAME</u> | <u>Page No.</u> |
|---|-----------------|
| <u>FREEDOM</u> , (Dr.) Robert Mark, Resumed | 5561 |
| Examination by Mr. Scott | 5561 |
| Examination by Mr. Ortved | 5588 |
| Cross-Examination by Mr. Percival | 5617 |
| Cross-Examination by Ms. Forster | 5701 |
| Cross-Examination by Mr. Hunt | 5728 |
| Cross-Examination by Ms. Symes | 5753 |

INDEX OF EXHIBITS

| <u>No.</u> | <u>Description</u> | <u>Page No.</u> |
|------------|--|-----------------|
| 170 | Tape of interview held with Ms. Nancy Hawkins, CBC Metro Morning and Dr. Robert Freedom. | 5654 |
| 171 | Copy of transcript of preliminary hearing, Volume 21, February 19, 1982. | 5663 |



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---Upon commencing at 10:00 a.m.

THE COMMISSIONER: Mr. Roland, are you going to proceed?

MR. ROLAND: I think my colleague Mr. Scott is.

THE COMMISSIONER: Oh, I'm sorry, I didn't see him. He is hidden away.

MR. SCOTT: I take it Mr. Percival is not going to begin?

THE COMMISSIONER: No. I think we decided yesterday we would go in the usual order which will give him lots of time to complete today.

MR. SCOTT: I will be very short.

DR. ROBERT MARK FREEDOM, Resumed
EXAMINATION BY MR. SCOTT:

Q. Doctor, you have had the advantage of reading Dr. Rowe's examination in chief and his cross-examination at my request.

A. That is correct.

Q. And beginning at page, in Volume - you don't have to get it out I don't think - but at Volume 19, at pages 3311 to 3436, Dr. Rowe analyzed in response to a series of questions from me what I call the mechanics of dying in a children's cardiac ward.



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Do you recall that?

A. Yes, I do.

Q. You will recall him saying that in every case of death in a cardiac children's ward cardiac arrest (that is heart stoppage of which there are fundamentally two types) is the characteristic final event.

A. I would agree.

Q. And he went on to explain that there are, dealing with juvenile cardiac patients, 14 underlying causes which are commonly seen which may cause that cardiac arrest. Do you remember that?

A. Yes.

Q. And he went through the symptoms, or I'm not sure what the right word is today, but the symptoms or the findings that might be observed in those 14 causes.

A. Right.

Q. And a common symptom with respect to every one of those causes was that the onset of the cardiac arrest could be characterized as sudden or unexpected.

Now he went on to deal with arrhythmias and bradycardias and so on, but that was a characteristic that he found in each of those modes of death.



1
2 Now in particular have you read that
3 evidence?

4 A. Yes, I have.

5 Q. Do you agree with it?

6 A. Yes, that the transition from
7 one basic rhythm to the mode of death, the electrical
8 mode of death, is sudden, yes, I do.

9 Q. And you would agree with
10 Dr. Rowe's assessment of the 14 potential causes of
11 heart stoppage that can occur in a juvenile cardiac
ward?

12 A. Yes, I do.

13 Q. And do you agree with his
14 analysis of the symptoms or findings in each of those
15 cases?

16 A. Yes.

17 Q. Does that evidence represent
18 the commonly understood opinion in your view of
cardiologists?

19 A. Yes.

20 Q. Now two of the causes which
21 he focused on were, and I haven't got the numbers
22 right, but were first a cardiac abnormality. Do you
remember that?

23 A. Yes.
24
25



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Q. And the second I want to draw your attention to - the second was of variety of electrical modes of death. Electrical modes that could cause heart stoppage.

6

A. Correct.

7

8

9

Q. And dealing with the electrical modes he brought to the attention of the Commission that this is probably the method by which digoxin poisoning causes heart stoppage.

10

A. Yes.

11

Q. And you agree with that?

12

A. Yes.

13

14

THE COMMISSIONER: I'm sorry, I don't understand. I am glad he agrees with it but I don't understand it.

15

16

17

MR. SCOTT: Well, you will recall in listening to the 14 methods that Dr. Rowe listed four electrical modes.

18

THE COMMISSIONER: Yes.

19

20

21

22

MR. SCOTT: That could cause heart stoppage. And he said that one of those modes included the administration of a poison, and he gave as an example digoxin, and that is how digoxin stops the heart. That was his evidence.

23

24

25

MR. LAMEK: Was that the one referred



1

2

to as conduction?

3

MR. SCOTT: Yes.

4

THE COMMISSIONER: What was that -

5

we have lost Mr. Elliot for the moment, but what was

6

that exhibit?

7

MR. SCOTT: It is not an exhibit,

8

Mr. Commissioner.

9

THE COMMISSIONER: Well, it may or
may not matter, but I don't understand, that is all.

10

MR. SCOTT: Well, you will recall,

11

Mr. Commissioner, that Dr. Rowe said to the Commission

12

that the stoppage of the heart is what causes death?

13

THE COMMISSIONER: Yes.

14

MR. SCOTT: And what doctors look

15

for is an underlying cause.

16

THE COMMISSIONER: That is right.

17

MR. SCOTT: And he listed 14 of those.

18

THE COMMISSIONER: Yes. I remember

19

that.

20

MR. SCOTT: Four of them were

21

conduction or electrical mode methods of heart
stoppage.

22

THE COMMISSIONER: Yes.

23

MR. SCOTT: One of those four was

24

induced by the injection or the absorption of a

25



1

2

poison of some kind.

3

THE COMMISSIONER: Yes.

4

5

MR. SCOTT: Q. Have I got it right
so far, Doctor?

6

A. Yes.

7

8

9

10

MR. SCOTT: And he gave as an
example, digoxin. If digoxin was administered the
mode by which it might kill, the mode by which it
might stop the heart, is a conduction or electrical
mode.

11

THE COMMISSIONER: Yes. All right.

12

13

14

MR. SCOTT: Q. Now are there other
substances commonly used in a hospital that may cause
heart stoppage in the same way as digoxin?

15

A. Yes, there are.

16

17

18

19

Q. And could you list for the
Commission substances which might be administered
for therapeutic purposes in a hospital but which
could cause death if administered to excess as digoxin
might?

20

A. Certainly one would have to
consider potassium.

21

22

Q. Yes.

23

A. Which can stop the heart.

24

Q. Yes.

25



1
2 A. One must consider excessive
3 amounts of calcium.

4 Q. Yes.

5 A. And again that is used almost
6 daily in most wards of the Hospital.

7 One would have to consider other
8 types of cardiac medications such as quinidine
9 which can cause ventricular dysrhythmias; inderol
10 or propanolol which can cause profound bradycardia,
11 and as well one would have to consider other agents
12 where the effect is not directly on the heart but
13 where there would be secondary effects on the heart
14 such as a paralytic agent, curare succinylcholine
15 and that type of medication.

16 Q. And if any of these drugs
17 were administered to a toxic degree to a patient would
18 the patient die by the conduction mode? Would his
19 heart stop as a result of the conduction mode?

20 A. I would certainly think,
21 Mr. Scott, that if one gave potassium, quinidine,
22 hyper amounts of calcium and the like one could cause
23 a severe conduction disturbance that would terminate
24 in death.

25 Q. Now if one of those poisons
were used, would there be anything that would point



1
2 to it as the cause of death rather than to digoxin?

3 Is my question clear?

4 A. Yes, it is. I would think in
5 response to the medications that are listed secondarily,
6 excluding the paralytic agents, the answer to that
7 would be superficially I couldn't think of a way to
8 distinguish them.

9 Q. All right. Now I'm leaving
10 aside a serum level.

11 A. No, I understand that.

12 Q. If you leave aside a serum
13 level is there any --

14 THE COMMISSIONER: If you leave
15 aside?

16 MR. SCOTT: A serum level.

17 THE COMMISSIONER: Oh, yes, you
18 mean a measurement of --

19 MR. SCOTT: Yes.

20 Q. Is there any characteristic
21 in the method of dying that will separate out digoxin
22 poisoning from any of the other methods of poisoning
23 except the paralytic agents that you have described?

24 A. I think appreciating the fact
25 that infants and youngsters can die with a bradycardia
or a ventricular dysrhythmia, I would not be able to



1
2 distinguish - excuse me, in the absence of medications,
3 I would not be able to distinguish the modes of death.

4 Q. All right.

5 THE COMMISSIONER: Could I just
6 interrupt for a moment?

7 An ordinary poison - I don't know
8 whether I can speak of ordinary poisons, what we
9 think of as ordinary poisons children pick up around
10 the house --

11 THE WITNESS: Yes.

12 THE COMMISSIONER: Cleaning agents
13 and things of that nature, would you be able to tell
14 the difference between a mode of death in that sort
15 of poison?

16 THE WITNESS: Yes, in the sense that
17 a lot of the things, Mr. Commissioner, that children
18 get into in the house which are detergents and
19 cleaning agents, they are caustic, they burn the
20 mouth, and --

21 THE COMMISSIONER: But let's say
22 the symptoms, the symptoms we are talking about
23 causing death, arrhythmia and seizures and all
24 these things that have been mentioned over and over
25 again, do they not demonstrate the same --

THE WITNESS: Yes, they certainly



1
2 could.

3 THE COMMISSIONER: And the only way
4 you would be able to tell would be because of the
5 effect of the poison?

6 THE WITNESS: Correct.

7 THE COMMISSIONER: And there are
8 some basic symptoms that apply to poison and to
9 several other causes of death, are there not?

10 THE WITNESS: Yes, but I think that
11 poisoning is not necessarily - one is not aware of
12 being poisoned, and I think a classic example that
13 comes to my mind is carbon monoxide poisoning.

14 One doesn't know that one is dying of
15 carbon monoxide until one is dead in the sense that
16 you don't have a perception; you are feeling fine
17 and you go to sleep very gently. You know, as one
18 reads the current newspapers about lethal injections
19 for the condemned on death row, the point of giving
20 those people the narcolytic and paralytic agents is
21 hopefully they don't feel much.

22 MR. SCOTT: Q. But I take it,
23 Doctor, in terms of analyzing why the death was
24 caused after the death, there are a number of tests
25 you can do, a serum level post mortem or ante mortem,
might be useful.



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A. I think if one were trying to differentiate why a patient died, if one were considering toxicology the answer to that of course would be yes.

6

7

Q. And an analysis of the contents of the stomach might be useful in certain cases.

8

A. Yes.

9

10

11

Q. And an analysis as you have just said to the Commissioner or whether there were burns that would be caused by the administration of a poison might be significant.

12

A. Correct.

13

Q. In certain cases.

14

A. Correct.

15

16

17

18

19

20

21

22

Q. But what I am talking about is with respect to digoxin and the other poisons that you have described - I shouldn't say poisons; the other therapeutic medications that can kill that are used in a hospital that you have described - is there any way that modern science has of differentiating which of those potential poisons cause the death without having somebody stand up and say I administered this?

23

A. To my knowledge the answer would be no.

24

25



1
2
3 during the hospital stay, and makes a judgment as to
4 those factors which you feel was causing the child's
5 death.

6 Q. And what is the source of your
7 evidence? First of all you look at the clinical
8 record?

9 A. You look at the clinical
10 record; you talk, if you were not directly responsible
11 for the patient, you talk to those physicians that
12 are. You review the chart, the chemistry levels
13 that are obtained, the medication levels that are
14 appropriate for the youngster's weight, and the
15 level of kidney function, and you go through a check
16 list of those factors and events which you think can
17 modify this child's life.

18 Q. All right. Now, in these
19 cases when you are doing that, absent a murderer, I
20 mean leave out a murder theory for the moment, if a
21 child has not according to the records of the
22 Hospital been administered digoxin at the Hospital
23 or anywhere else.

24 A. I would not consider digoxin
25 intoxication in that child's cause of death.

Q. Well, can I go further and
suggest to you, Doctor, that if you did consider



1

2

digoxin poisoning in that case, you might be a

3

terrific detective but you would be unscientific?

4

A. Correct.

5

Q. There would be no evidence for

6

it?

7

A. Correct.

8

Q. Now dealing with those cases

9

where there is evidence on the record that there has

10

been digoxin administered, what do you do when you

11

come to consider that as a potential cause in those

12

circumstances?

13

A. Again I think that one reviews

14

the digoxin dosage as ordered in regards to the

15

patient's weight, the timing of the digoxin administra-

16

tion vis-a-vis the child's death, the level of kidney

17

function, and of course whether or not a digoxin level

18

has been obtained.

19

Q. All right. Now leaving aside

20

the Estrella reading post mortem which you have

21

described.

22

A. Yes.

23

Q. And coming down to Saturday,

24

March 20th.

25

A. 21st.

Q. 21st, when you heard about the



1

2

Allana Miller reading --

3

A. Yes.

4

Q. On the evening of that day,

5

was there anything in the events of any of the deaths

6

with which you were concerned that pointed to a

7

conduction mode of death caused by digoxin overdose?

7

A. No.

8

Q. In the deaths with which you

9

were concerned was there evidence on the record that

10

pointed to another mode of death as more probable?

11

A. Yes.

12

Q. Or as the probable cause of

13

death?

14

A. Yes.

15

THE COMMISSIONER: I am sorry, the
premise to this question, is it leaving aside Estrella?

16

MR. SCOTT: Leaving aside the

17

postmortem reading in Estrella.

18

THE COMMISSIONER: Yes.

19

MR. SCOTT: But considering Estrella,

20

absent the postmortem reading.

21

THE COMMISSIONER: Yes.

22

MR. SCOTT: And right down to the

23

Miller reading, Baby Miller reading, which was I think
obtained the evening of the 21st.

24

25



1

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THE WITNESS: . Right.

3

MR. SCOTT: Q. Well now we know

4

that at least one baby had an antemortem reading of

5

greater than 9.4 and lived for four days.

6

A. Correct.

7

8

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Q. All right. So in order to focus on digoxin rather than on potassium, you have got to have a confession from somebody that we administered digoxin rather than potassium?

6

A. Yes. That would be my feeling.

7

8

9

10

11

12

13

Q. All right. Now when a doctor comes as you and the other doctors were required to do from time to time and particularly beginning in July with these deaths with which the Commission is concerned, you find that a baby on your ward has died suddenly and unexpectedly, the onset of symptoms is sudden and unexpected in the way Dr. Rowe described for each of these 14 causes. Right?

14

A. Right.

15

16

17

Q. He can determine whether there was bradycardia, arrhythmia and all the rest of it, but he can look at the symptoms that Dr. Rowe described?

18

19

20

21

A. Correct.

Q. All right. Now how do you decide which of the 14 methods of dying, including poisoning, was the method of dying on the balance of probabilities?

22

23

24

25

A. I think one reviews the patient, the type of anatomy the patient has, the intercurrent and secondary illnesses the patient may have developed



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(Scott)

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Q. And that's the Estrella baby?

3

A. Correct.

4

Q. That reading appears to be a
high one?

5

A. Yes.

6

7

Q. Right. Now, Dr. Rowe said in
his evidence - I don't have the page but I can dig it
up - he said that a doctor prescribes digoxin for a
fact.

8

9

10

A. Yes.

11

Q. Not for a reading?

12

A. Correct.

13

Q. Can you tell the Commissioner if
you agree with that and what you understand it to mean?

14

15

A. Yes. Well, as I have said, and
I can't remember whether I said it in this forum or
in the sessions with Mr. Lamek before this meeting,
digoxin, first of all, the routine digoxin dosages
vary from institution to institution. In Sick
Children's we use a rather lower total dose than other
hospitals; that's No. 1. No. 2, one gives digoxin
in order to achieve a certain clinical effect, that
is, to improve the symptoms of congestion and heart
failure and one is guided, and certainly before the
days of digoxin levels, one is guided by the clinical
effect on the individual patient.

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B.2

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Q. And the clinical effect is an increased pumping action?

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A. It's improvement of the heart congestion, stronger heart activity, better excretion in the sense of better well-being.

5

6

7

Q. And do I understand from that that you give more or less digoxin as you observe whether that effect has occurred?

8

9

A. Correct.

10

11

Q. Now, we know that many babies can take digoxin levels of 6 and 7 and 8, don't we?

12

A. Yes.

13

Q. Yes. And we know that one baby took a digoxin level of greater than 9.4 and lived?

14

A. Correct.

15

16

Q. Yes. Now, are you familiar with serum levels of that dimension?

17

A. Yes.

18

19

Q. In dealing with living patients, what's the highest serum level for digoxin in connection with children with which you are familiar?

20

21

A. I can remember several children over a number of years who got into the grandmother's or parent's digoxin with inadvertent overdosages.

22

23

Q. Well, let me stop you there.

24

25



B.3

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These would be patients who came to you because they
had taken their parent's digoxin?

4

A. Correct.

5

Q. Or their grandparent's digoxin?

6

A. Correct.

7

Q. All right.

8

A. I have seen levels as high as
14, 16.

9

Q. And did those patients live?

10

A. Yes.

11

Q. So, it is highly variable?

12

A. Correct.

13

THE COMMISSIONER: I'm sorry, are
these in your own experience?

14

THE WITNESS: Yes.

15

THE COMMISSIONER: Right.

16

MR. SCOTT: Q. And have you read in

17

the literature of comparable experiences to your own?

18

A. Yes.

19

THE COMMISSIONER: Can you tell me
something about those children who did swallow it? What
happened, I take it they were immediately brought down
to the Hospital. When are the levels taken? The
first thing you do I suppose is pump their stomach,
is that correct?

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B.4

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THE WITNESS: Yes, you pump the stomach and you give them intravenous, fluids. Often they need supplemental potassium.

5

6

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THE COMMISSIONER: But what I am thinking about is if the child had been left alone for four or five hours, and would have had to have been left alone I would think for four or five hours before it would attain this level, would it not?

9

10

11

THE WITNESS: Well, again, I think it is often difficult to tell exactly from the literature how long a child has taken the digoxin.

12

13

THE COMMISSIONER: Yes. But we know if you take it orally the effect won't be ---

14

15

THE WITNESS: Yes, for a number of hours, that is correct.

16

17

18

19

20

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THE COMMISSIONER: For a number of hours.

THE WITNESS: Correct. So, often these children will come in with a history that the parents or grandparents found them with an open bottle of digoxin, tablets strewn around and they will pump the stomach, they will draw a digoxin level, but the concern is they won't know exactly when it has been taken. So, they will have one level, they will then start monitoring the child very closely and often take a subsequent level to see how it peaks. I have had to



B.5

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put in a pacemaker for a child who's had bradycardia
and tachycardia with digoxin poisoning.

3

4

MR. SCOTT: Q. Let me ask you this.

5

When did serum readings become routinely available?

6

7

8

A. I know they have been used for
a number of years, Mr. Scott, in more of an experi-
mental concern. Certainly when I was in Baltimore,
which was 10 years ago, we weren't doing them

9

10

routinely. I can't remember, maybe till about five
years ago, four or five years ago, Sick Children
started to get a number of digoxin levels.

11

12

13

14

15

Q. All right. So, it is only in
the relatively recent past, say, five or six years,
that a hospital and cardiologists has had access to
a serum level reading to tell him something about the
volume of digoxin that remains in the serum?

16

17

18

A. Correct.

19

20

Q. Yes, alright. Now, before there
were serum readings --

21

22

23

24

25

A. Yes.

Q. -- how did you know when to stop
administering digoxin?

A. Well, I'm going to interpret
your question a little bit differently. You mean how
did we know if a child was having enough digoxin versus
the need to stop it at all?



B.6

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Q. Yes.

A. Again, I think one would look for the desired clinical effect, one would look for EKG changes such as dysrhythmias, and one would then make the clinical judgment as to whether the dose was appropriate or whether one should decrease the dose.

Q. And that was done without the serum device?

A. Correct.

Q. Yes, all right.

THE COMMISSIONER: You said that the serum started, and I think we have had this before, but it started about five years ago?

THE WITNESS: I think it has certainly been available in more of an experimental mode, Mr. Commissioner, for longer than that, but I date it to about five years at Sick Children's.

THE COMMISSIONER: And you're talking about five years from 1983?

THE WITNESS: Yes.

THE COMMISSIONER: So, that would be about 1978?

THE WITNESS: Yes.

MR. SCOTT: Q. As a relative routine?

A. Well, again, perhaps Dr. Rowe



B.7

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gave evidence to the contrary but I just think of it
in the last five or six years as more of a routine
of the Hospital; I may be wrong.

4

5

6

7

8

Q. Well, what I'm asking you is,
when the clinician treating a child sees that the
child is doing nicely but has readings of greater than
4.7, or something like that, is there anything
intrinsically alarming in that?

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A. I would say one sees a number,
one interprets that in view of the clinical well-being
of the child but because there are guidelines for
serum levels now, one would say that it is certainly
at the upper range of what would be considered in the
various institution and one would probably back off.

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Q. Yes.

A. Even in the complete absence of
symptoms.

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Q. But what I'm getting at is, does
an elevated serum level of that dimension suggest
anything except - does it suggest anything connected
with foul play?

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A. No, not at all.

Q. It is a perfectly normal thing
in that sense?

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A. Yes.



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Q. It may be designed to cut back but it is not, or is it evidence that there has been some tampering with the patient?

A. Not at all.

THE COMMISSIONER: Well, when you say an elevated level is not a sign of foul play, a level, if you were to get a ridiculous level of 100 nanograms it would be evidence of something other than the ordinary dosage because that couldn't happen. Would I not be right?

THE WITNESS: Well, again, I'm not ---

THE COMMISSIONER: We are now talking theory because this didn't happen in any living child; if it were to happen --

THE WITNESS: Well, again, my response Mr. Commissioner, was to Mr. Scott's level of 4.7.

THE COMMISSIONER: Yes.

THE WITNESS: My pharmacokineticist colleagues, I'm sure you will have heard or will hear from them, tell me if you give a dose to a patient almost what is considered an appropriate dose and if it is sampled almost immediately one can get extremely high levels way beyond 4.7. So, I would agree with your comment that if it had levels of 100 during life there is something very - it has to be explained.



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MR. SCOTT: Q. Well, let me put this to you. We will allow the pharmacologist to speak about postmortem samples.

A. Yes.

Q. And what if anything you can learn from that.

A. Right.

Q. And I take it that is their discipline, isn't it?

A. Yes.

Q. Yes. Well, let's deal with ante-mortem serum testing.

A. Okay.

Q. If you saw an elevated level, let's say to begin with 4.7, would that suggest anything out of the ordinary?

A. No.

Q. All right. Now, would it suggest in particular any tampering with the patient?

A. No.

Q. All right. If you saw a level of 10, would that suggest anything out of the ordinary to a clinician? I'm not asking would he react to it, but would he see foul play if he saw 10?

A. No. I have certainly seen levels



B.10

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of 10 in critically ill newborns who have kidney
shutdown.

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Q. And I take it that in those
cases you may want to cut back?

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A. Correct, or certainly you
wouldn't even cut back, one would stop the digoxin
at that point.

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Q. All right. But do I understand
that those levels can occur - by the way, with the
exception of one, none of them occurred in these cases
pre mortem, ante mortem, but those levels can occur
with the therapeutic administration of digoxin in
appropriate quantities?

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A. Yes.

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Q. Now, one last question. Leaving
aside post mortem readings, is there any characteristic
of digoxin poisoning that enables you to say the
presence of that characteristic points to digoxin and
nothing else?

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A. No.

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Q. One other thing. At page 3435
and 3552 Dr. Rowe dealt with what a clinician in
juvenile cardiac wards expects by way of nursing notes.
Do you recall reading that?

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A. Yes, I do.



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Q. And he described to the Commission the kinds of things that he expected competent nurses to note and the use that the clinician makes of those notes?

A. Correct.

Q. Do you agree with his observations in that respect as a practical matter?

A. Yes, I do.

Q. Yes. He then went on to say that there were a number of important things that the clinician himself would observe which he would not routinely expect a nurse to note?

A. Yes, I would agree with that as well.

Q. And you would agree with his evidence on that score?

A. Yes.

Q. Yes. And that those observations can be significant and critical in determining the condition of the child from hour to hour or day to day?

A. Right.

Q. Yes.

MR. SCOTT: I think those are all the questions that I have, thank you, Dr. Freedom.

THE COMMISSIONER: Yes, thank you.
Mr. Ortved?



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MR. SCOTT: I am trying to be a model of brevity and how am I doing?

THE COMMISSIONER: You've done well, you've done well, you have indeed.

MR. SCOTT: Thank you, Mr. Commissioner.

EXAMINATION BY MR. ORTVED:

Q Just to follow up briefly on one matter that was just canvassed by Mr. Scott, Dr. Freedom. You will recall yesterday, and I am speaking now in terms of symptoms that may or may not be indicative of digoxin intoxication. You have indicated that there are no symptoms that are indicative of that and would rule out any other cause of death. Is that correct?

A. Yes.

Q And you will recall yesterday in an exchange with Miss Cronk, and it is to be found in Volume 29 at page 5,365, that you were taken through a list of items which may be symptomatic of digoxin intoxication. Do you recall that?

A. Yes.

Q And they included bradycardia?

A. Correct.

Q Ventricular fibrillation?

A. Right.



D.13

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Q. Heart block or partial heart

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block?

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A. Right.

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Q. EKG changes?

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A. Correct.

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Q. And you added in young babies

increasing lethargy?

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A. Right.

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Q. Now, this may be unnecessary but

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are those symptoms equally to be found with any one

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of a number of other causes of death?

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A. Yes. I think certainly poor

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feeding, lethargy, vomiting is a sign of an ill baby

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whether or not he's on digoxin; No. 2, I think as we

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have seen from the paper from Columbia that has

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already been put into evidence, we know that babies

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not on digoxin will die and their electrical mode of

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death is bradycardia or can be bradycardia in the

19

majority. Some will have ventricular dysrhythmias.

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So, again, Mr. Ortved, there is nothing between looking

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at a mode of death of a baby dying with digoxin

poisoning versus the mode of death of a sick baby that

I could distinguish.

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Q. All right. Now, I would like to

23

commence if I may by taking you to the numbers of

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ANGUS. STONEHOUSE & CO. LTD
TORONTO, ONTARIO

Freedom, ex.
(Ortved)

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B.14

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deaths. For your convenience they are plotted
more or less accurately - we'll hear about that - by
the green line on the graph that you see on your
right.

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THE COMMISSIONER: Is that the green line, we are talking about the deaths on the wards?

MR. ORTVED: Deaths on the ward.

THE COMMISSIONER: I would have thought it was blue, but I have had that trouble all my life, so maybe you are right, maybe it is green.

MR. ORTVED: All right, blue or green.

Q. Dr. Freedom, just going to the period July - August, 1980.

A. Yes.

Q. Can you assist me whether there was a perception on the part of the Division that there had been an experience with an increased number of deaths on the ward?

A. Yes. I think that I and my colleagues felt that we were seeing an increased number of babies that were younger and sicker, and that we were seeming to be clustered with very ill babies.

Q. Just looking at that graph, it is obvious that, in the months preceding July and August of 1980, the usual experience on the ward in terms of deaths had been in the range of something from zero to three, and on one occasion, four deaths, I think I am accurate in that, would that accord with



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your recollection?

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A. Yes.

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Q. July and August of 1980, you

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have five deaths respectively in each of those months?

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A. Right.

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Q. Did those numbers, in and of

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themselves, indicate to you that there was anything
amiss?

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A. I think we were certainly aware

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of what appeared to be an increased number of deaths

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on the floor. I think that these babies, most of

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them, were autopsied. We had evidence that they had

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terribly severe disease and lethal, and I think that

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all of the numbers were above what we had expected on

15

the old floor, which was 5A. We felt comfortable in

16

the sense that these babies had terrible disease, and

17

again, it seemed to support our feeling that these

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babies were clustered, were sicker than we had seen
in some preceding interval.

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Q. In your experience as a

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cardiologist, is this phenomenon of clustering

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something that is unknown?

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A. Conversely, I think that most

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cardiologists are aware of what we perceive as

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clustering.

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Q. Can you just elaborate on that?

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A. Clustering in the sense of groups

of malformations appearing in a shorter time framework.

That is, seeing a group of babies with transposition,

say, seeing six in two weeks versus six over six

months, seeing groups of babies with hypoplastic left

heart syndrome. Certainly there has been considerable

literature devoted to the seasonal clustering of

certain forms of heart malformations and I think most

of us are aware of that perception.

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Q. Coming then to January of 1981,

we know from the evidence of Dr. Rowe, with which you

are familiar, that you assisted in the review that

was presented at the meeting on January 12th, 1981, is

that correct?

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THE COMMISSIONER: I think he wasn't

present, he said.

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THE WITNESS: No, I wasn't.

THE COMMISSIONER: He did -- the only

thing I remember you doing was to add some names, did

you not?

THE WITNESS: Well, I think in evidence

there was a memo that said some names. I know Dr. Rowe

had asked me to get together some of the pathology

material. You are correct, Mr. Commissioner, I was



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3 not at that meeting.

4 Q. No, my point is, as I understand
5 it, you assisted, to some extent, in the preparation
6 of the material that was eventually distributed for
7 that meeting, is that correct?

8 A. That is correct.

9 Q. And was there a perception that,
10 or what was the perception on the part of yourself as
11 to the experience that was obvious upon completing that
12 review of the experience of the ward in terms of
13 deaths in that six month period?

14 A. Well, again, we were certainly
15 aware that the numbers were above what we had seen on
16 the old floor, 5A, that had a fewer number of beds,
17 number one.

18 Number two, there had been discussion
19 that there seemed to be more of the deaths happening
20 at night. We were concerned that perhaps this
21 reflected a relative reduction of nurses from the
22 day-time complement, and I think that there was an
23 ongoing concern that perhaps improved monitoring and
24 support for the sicker babies would be beneficial.

25 I believe, in response to the deaths
throughout the fall, Dr. Rowe and Dr. Fowler, in
discussion with the other staff had formalized, or



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3 were in the process of formalizing, the intermediate
4 risk observation units on the fourth floor. I think
5 it was the purpose of that type of implementation to,
6 one, improve the sophistication of monitors. Certainly,
7 the secondary benefit was that we would have more
8 nurses on the floor because that room would entail
9 close observation, one nurse for one or two patients.

10 Q. I think that you have already
11 indicated, in your evidence-in-chief, that in the
12 course of time and I am speaking specifically of
13 March, 1981, through until today, there has been a
14 change, or an alteration, on your part as to the
15 possible cause of death in relation to certain of
16 these children, would that be fair?

17 A. Yes. I was certainly very
18 convinced in March of 1981, being told about those
19 high digoxin levels, that unequivocally, I felt, back
20 in those days, it was murder.

21 Q. Has that perception altered as
22 of September the 8th, 1983?

23 A. Yes. I think all of us in this
24 room have learned a great deal about digoxin.
25 Certainly, my understanding of a postmortem digoxin
level in 1981 was that it carried the same significance
as a premortem level, I have learned otherwise.



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Q. There is reference that has been made, in this forum, to the case of Baby Murphy, who died earlier this year, you are aware of that, I take it?

A. Yes.

Q. And as I understand it, you had some very close personal contact with that particular case, did you not?

A. Yes, I was Ward Chief and Acting Director of the Division when the baby died.

Q. And did the experience and the evidence that you heard and gave in relation to Baby Murphy, is that one of the mileposts in terms of your continued learning about digoxin and its effects postmortem?

A. Yes. I, certainly that evening, or I guess it was early in the morning when we received a digoxin level in the 20s and 30s on Gary Murphy, and as we then went through the next few weeks, the coroner's and homicide investigation, finally to have it declared through the coroner's investigation that these levels were that of a natural cause, certainly would shade any of my concerns back to March of 1981. Take, for example, Pacsai, whose level, as I recall, was somewhat slightly lower and in the same



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range as the Murphy baby.

Q. You have been asked in the course of your examination-in-chief by Ms. Cronk about certain babies with whom you were very closely concerned as Ward Chief, correct?

A. Correct.

Q. And you have been taken through their charts, for instance, I think Monteith and Shrum would be two of those, correct?

A. Correct.

Q. One of the aspects with which we are here concerned is the ability to perceive the course and prognosis of a particular patient based upon a review of that patient's chart?

A. Right.

MR. SCOTT: Record.

MR. ORTVED: Record, excuse me, Mr. Commissioner.

THE COMMISSIONER: I had practically given up on that.

MR. ORTVED: I noted when Dr. Freedom took the stand and commenced using the word chart that you gazed wistfully.

THE COMMISSIONER: I winced a little, but then I decided you have to accept defeat,



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8 3 occasionally, so, however --- . The reason for that
4 is, and I recognize now that it is obviously common
5 in the hospital that refers to these records as charts.

6 The problem we were facing was that
7 when Dr. Rowe was here putting up, or giving us a
8 diagram of the condition of the heart which struck me
9 as being a lot closer to a chart than the book of
10 documents he was reading from. So, we tried it, it
11 failed I can see, it was not the only failure of my
12 life.

13 MR. ORTVED: Sometimes, even the judge
14 has to buckle under to an overwhelming ---

15 THE COMMISSIONER: I think the judge
16 buckles under more often than anybody else.

17 Q. Just dealing with the Monteith
18 case, for instance, Dr. Freedom. Can you assist me as
19 to whether the Ward Chief, which was yourself in that
20 case, whether there can be some material assistance to
21 the perception of a patient provided by the Ward Chief,
22 or by the attending physician, that may or may not be
23 obvious from a review of the chart?

24 A. Yes, I would certainly think that
25 the medical record provided a base line on which one
would like to try and formulate an opinion. I think
that certainly the advantage of seeing the child and



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listening to the child is as one, for instance, reviews nursing notes, there can be a vast difference between two babies breathing at 80 times a minute with a heart rate of 160, and if the attending physician has not written a note in the chart, but was aware of difference in physical findings, that would certainly be most helpful to one reviewing such a chart.

Q. I know it has been covered here, already here on more than one occasion, but, in fact, did you as an attending physician, for instance in relation to Monteith, were you in the habit of making regular progress notes?

A. No. Back in those days, I was not, certainly I am now.

Q. Can you assist us, elaborating upon that remark?

A. Well, I have felt that for years, and it was my training in Boston where we were -- it was felt to be an important part of a teaching hospital not to subvert the house officers and fellows by the staff writing notes, but interns would put footnotes on the charts, and that certainly if the staff did it, that would probably subvert their willingness to do so. So, I have been very conscientious over the years in making thorough consultation notes, dictating letters,



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with some exceptions, that were fairly accurate and to the point. Until these proceedings, since March of 1981, I have become somewhat of a hypocrite and I have now started, as much as possible, when I am Ward Chief, putting some progress notes on the chart as well.

THE COMMISSIONER: You indicated the custom was for interns and residents to do it, is that right, they would make full notes but not the Ward Chief?

THE WITNESS: Yes.

THE COMMISSIONER: What about the fellows?

THE WITNESS: Yes, the fellows, Mr. Commissioner, at least here at Sick Children's would make progress notes. Often, they would be in the so-called Zebra form, these are part of the on-going cardiac records of all the children in the Hospital for Sick Children. They are often, though not infrequently, the fellows notes would not be on the hospital record, but would be in the so-called Zebra record or packet.

Q. And based upon what has been your experience since March of 1981, in terms of making your own on-going notes in addition to those of your residents on the floor, can you assist me as to



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2 whether those sometimes reflect a change in perception
3 as to the cause of an individual patient?

4 A. Yes. I think not infrequently,
5 I think it comes with experience, I will see something in
6 terms of a gallop rythmn that my resident won't have,
7 so I think it does add an added dimension to a chart.

8 Q. And also, as I understand it,
9 going back to this business of reviewing charts, is it
10 in fact the case that different institutions have
11 different or varying experiences with varying kinds of
12 disease that may not be reflected in the chart per se?

13 A. Yes. I would certainly think
14 that, as a physician from another institution would
15 review a chart of a cardiac patient that not only is
16 he influenced by what he reads in the chart, or perhaps
17 what he doesn't read, but he would certainly be
18 influenced by his own experience.

19 If I can just take an example, I think
20 there are certain lesions that the Hospital for Sick
21 Children here in Toronto, we have a suberb surgical
22 expertise where we would suggest that type of patient
23 has a low mortality. You take the same patient in a
24 different institution where the mortality is much
25 higher, and that physician would certainly regard that
disease with a different optimism or pessimism.



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The converse is true, as well. There are certain lesions in Toronto that we have had extremely poor success with, where other institutions would have much better success, this is unusual but it can happen.

Q. Can you relate that to any patient that we might have encountered in the course of our evidence?

A.

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MT/PS

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3 A. Yes, specifically if one takes
4 the lesion truncus arteriosus, the mortality here
5 at the Hospital for Sick Children for any group of
6 infants under six months of age with truncus
7 arteriosus is extremely poor. And I would suggest
8 our mortality is in the range of 90 percent. Maybe
9 even a little bit higher or a little bit lower, but
10 still it is extremely unfavorable.

11 There is one institution in North
12 America where they say the surgeon's hands are guided
13 by the good Lord where he has a mortality of much lower.
14 Ten or twenty percent. So I would think that if
15 one reviewed -- if a physician from the institution
16 where the results are very good would come to
17 Toronto, review a chart and see the diagnosis
18 truncus arteriosus his expectation for how well
19 that baby should do would certainly be better than
20 ours.

21 O. And as you have told us, I
22 believe the converse is also true?

23 A. Correct.

24 O. Then I would like to take you
25 if I might to your evidence concerning baby
Woodcock.

A. Yes.



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3 Q. You recall being asked a
4 question concerning that child in chief by Ms.
5 Cronk?

6 A. Yes.

7 Q. I am referring specifically,
8 Mr. Commissioner to Volume 28 of September 6th,
9 Page 5152.

10 You were asked, Dr. Freedom, about
11 your opinion as to the cause of death in that child.
12 Do you recall that?

13 A. Yes.

14 Q. Perhaps just to refresh your
15 memory, I will read those questions and answers.
16 They commence at the bottom of Page 5152, question
17 by Ms. Cronk.

18 "Q. Sitting here today, Dr. Freedom,
19 do you have an opinion as to the
20 probable cause of death of this child
21 in light of the post mortem findings?

22 A. You know, post mortem the
23 youngster had fluid in chest cavities
24 in the abdomen, and I wonder whether
25 this process was a toxic process of
the bilirubin directed towards the
central nervous system.



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Q. And do you find support for that concern, Doctor, in anything contained in either the preliminary or final autopsy report?

A. Yes, first of all they talk on number one and two, the patient had extensive bilateral pneumonia."

And then there is an exchange; I will skip and go to the bottom of the page.

"A. Again, if it described giant cell formation, Ms. Cronk, that is not just based on preliminary information, that is using a microscope. So, this youngster had extensive pneumonia bilateral with congestion and edema; that's number one. Number two, he had a severe cholemsis..."

I think that probably should be --

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"A. ...cholangitis.

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Q. Cholangitis, and that means plugging of the liver with bilirubin.

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There was congestion of the organs as listed in number seven. So again, this was obviously an ill youngster but it was apparent that the heart disease

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holds relatively little risk to this
baby in isolation."

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And then you were taken to the final autopsy report
where there is reference to the sudden cardiac arrest
and the cause of it being uncertain, and at Page 5155
you were asked:

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"Q. In light of the significant
matters which you have in your view
pointed out in the autopsy report, do I
take it that you are satisfied as to the
probable cause of death of this child
in the arrest that she sustained, not-
withstanding the observations made in
the final paragraph of the autopsy report?"

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And your answer was:

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"A. Yes. I believe it is not uncommon,
Ms. Cronk, to have a child or an infant
with a viral process causing pneumonia
where the virus is not invariably
cultured. I would be satisfied that it
was unlikely that this was caused
through a bacterial process."

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Now, the only item to which I would direct you is
contained in Exhibit No. 150.

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Mr. Elliot, 150?



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Now, Exhibit 150 is a number of
coroner's investigation statements which have been
filed.

If I could take you to the Woodcock
one. I believe it is the last page of Exhibit 150,
Mr. Commissioner.

THE COMMISSIONER: It is not on mine.
Taylor is the last page.

MR. ORTVÉD: It is the coroner's
investigation statement for Dr. Cass dated August 7,
I guess, or it might be July 8th.

THE COMMISSIONER: It is not in my
copy of Exhibit 150. Could I see yours, Doctor?

MS. CRONK: To assist you, Mr.
Commissioner, the Woodcock coroner's report was marked sep-
arately from the rest of the bundle but it does
bear the number.

Q. Yes. Well, I guess this exhibit
didn't arrive. It wasn't put in at the same time.
Well, all right. I will survive, I think, without it,
if you will tell me...

MR. ORTVÉD: Q. Well, the only point
is, Dr. Freedom, that as you know Laura Woodcock
was one of the cases which was referred to the
coroner's office, is that correct?



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A. Correct.

Q. And that was a decision made on the part of Dr. Rowe?

A. Correct, as I understand it.

Q. And one with which you agree or disagree?

A. One with which I agree.

Q. That case was subsequently investigated by the coroner and do you have before you a coroner's investigation statement on the part of Dr. Eli Cass dated I guess July 8th of 1980?

A. Yes.

Q. And in that coroner's investigation statement under Arabic 2, Dr. Cass reports the results of his investigation as follows:

"Date of death, June 30, 1980.

Place of death, Hospital for Sick

Children.

Cause of death, congenital heart disease.

By what means, natural causes."

Is that right?

A. Correct.

Q. So it would appear that Dr. Cass at least concurred with the opinion you gave Ms. Cronk yesterday that you were satisfied the death of



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3 Laura Woodcock occurred by way of natural causes;
4 correct?

5 A. Right.

6 Q. So also under Arabic 3 in the
7 document, Dr. Cass' comment under the heading, "My
8 investigation revealed the following additional
9 information," the last sentence of which reads:

10 "Upon my investigation I was satisfied
11 that death was due to natural causes and
12 determined that no official autopsy or
13 inquest was necessary."

14 Do you see that line?

15 A. Yes, I do.

16 Q. So Dr. Cass would appear to have
17 conducted an ordinary investigation and was satisfied
18 as to the cause of death, correct?

19 A. Correct.

20 Q. And in February Dr. Cass, as Ms.
21 Cronk put to you, the results of any post mortem
22 digoxin analysis on serum or tissues was not available
23 to Dr. Cass as it was not available to you.

24 A. Correct.

25 Q. Then if I can take you to your
evidence regarding John Onofre, that is to be found
in Volume No. 29 for September 7 at Page 5381.



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3 You will recall, Dr. Freedom, the
4 evidence concerning John Onofre you were taken through
5 the terminal events and asked your opinion as to the
6 cause of death of John Onofre.

7 A. Correct.

8 Q. You gave that, and I am summarizing
9 certain of these pages: you looked to the dysrhythmia, the
10 arrhythmia as suffered by this child, the contraction
11 and necrosis found on autopsy and the issue of sepsis
12 and felt that either singly or in combination those
13 factors would certainly explain that death to you.

14 A. That is correct.

15 Q. Then do you recall how Ms. Cronk
16 took you to the final autopsy report in that case, and
17 you respond at Page 33 of Exhibit No. 70, and she read
18 you a portion of the final paragraph of that final
19 autopsy report, namely:

20 "Death in this case was somewhat sudden
21 and unexpected being manifested by sudden
22 onset of bradycardia and cardiac arrest.
23 In view of the subsequent cases on this
24 ward of digoxin overdose, this must now
25 be raised as a possibility but there is no
confirmation of this since at the time
of the gross autopsy it was not considered.



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Because of this possibility, in this respect the coroner's office (Dr. Tepperman) has been notified (June 30th, 1981)."

Do you recall being read that portion?

A. Yes, I do.

Q. Ms. Cronk also at Page 5382 pointed out the arrhythmia suffered by this child and asked you:

"Doctor, would you agree with me that arrhythmias in certain situations are of and in themselves symptomatic of digoxin intoxication?"

To which you replied in the affirmative.

A. Correct.

Q. What Ms. Cronk didn't point out to you, and I think it is of some importance, is the remainder of the final paragraph of that final autopsy report.

THE COMMISSIONER: What page?

MR. ORTVED: That is Page 33, Mr. Commissioner.

Q. And that provides as follows, Dr. Freedom:

"In this patient there are several other



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even more likely precipitating causes of death, namely, an arrhythmia and/or sepsis and/or enteric infection. The patient was being investigated for an arrhythmia, in fact that's why he was referred here. Some problems with dysrhythmia were noted in the period immediately prior to death. In addition, contraction band myocardial degeneration was noted histologically. It is possible that foci of myocardial degeneration or necrosis could have acted as foci for electrical instability and precipitated the fetal dysrhythmia. Alternatively, however, several bacteriological cultures obtained from segments of several different sites grew *E. Coli*. The interval from death to autopsy was five hours and the positive cultures obtained are thus considered significant. *E. Coli* septicemia may have contributed in a significant manner to this infant's death."

Do you see that portion?

A. Yes, I do.



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Q. And do those findings on the part of the pathologist accord with your views as to the likely cause of this child's death?

A. Yes, they do.

Q. And these it would appear from this paragraph observations on the part of the pathologist are in light of the information and arrest, events that followed March 21 and 22 of 1981?

A. Correct.

Q. Lastly, Dr. Freedom, in your evidence yesterday you were taken through the case of Allana Miller.

A. Correct.

Q. And in particular at Page 5524 of Volume No. 29 you were queried as to your view as to the cause of death in this child as of the morning of March 21st, 1981?

A. Correct.

Q. Subsequently -- I will read the question and answer which provides as follows at the bottom of the page:

"Q. Prior to learning of that post mortem digoxin level, Doctor, at the time that you participated or observed the gross autopsy and examined



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the child's heart, based on those observations and your knowledge of her clinical condition, did you at that stage formulate an opinion as to her likely cause of death?

A. Yes, I felt that although she had looked improved when I saw her some seven or eight hours before her death, she still had very severe heart disease and underlying dysrhythmia and a very poor weight gain. I thought that seeing the huge hole in her heart and the congested lungs that this would explain her death, it did explain her death.

Q. Were there any factors recorded in the medical record of the child or any terminal events that were drawn to your attention upon which you in part or in whole based that opinion, Doctor?

A. No. Again, I think it was sort of the entire perception of little Allana Miller, since she had gotten sicker over the months and not gained weight and had a very big heart,



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and the autopsy table seeing a very much
enlarged heart. The virtual common
atrium, the lack of partition and the
congested lungs."

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So my only point is this: as of the time you participated
in that gross autopsy, and I think you indicated that
was at or about the time of the catheterization
procedure you were performing on the morning of
March 21st, 1981?

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A. Right. It was either between
the two caths I did or right after.

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O. All right. What was your view
as to whether or not there was anything suspicious
about the death of Allana Miller?

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A. Not at that time.

Q. And what was your view as of
that point in time as to whether or not the case of
Allana Miller would have been one appropriately
reported to the coroner at that point in time?

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A. As of that morning or early after-
noon this baby had been in the hospital, had severe
heart disease and although I wasn't ward chief,
reviewing it then and now I wouldn't have found
a reason to report it to the coroner.

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MR. ORTVÉD: Thank you.



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Those are my questions, Mr.
Commissioner.

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THE COMMISSIONER: Yes, thank you, Mr.
Ortved.

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THE COMMISSIONER: Mr. Percival, do you
want to proceed now?

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MR. PERCIVAL: I am not going to finish--

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THE COMMISSIONER: No, no. We can have
the break now or --

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MR. PERCIVAL: I would like to break now,
if that would be all right.

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THE COMMISSIONER: All right.

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MR. PERCIVAL: I will certainly finish
before one with no difficulty.

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THE COMMISSIONER: Yes. You want
to be able to be finished by one, in any event.

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MR. PERCIVAL: Yes.

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THE COMMISSIONER: We will break now
for twenty minutes.

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---Short recess.

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---Upon resuming.

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THE COMMISSIONER: Yes, Mr. Percival.

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CROSS-EXAMINATION BY Mr. PERCIVAL:

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Q. Dr. Freedom, the nature of

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this Inquiry is investigation into a series of deaths

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which occurred on Wards 4A and 4B from July of '80 to

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March of '81. Dr. Rowe has earlier alluded to some

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of the reactions that he felt as a physician during

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that time period. He also talked in terms of certain

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M and M conferences that occurred, two of them I

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believe on September 5th and September 29th, 1980
and one in January, I believe January 15th of 1981.

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MR. ORTVED: January 12th.

14

MR. PERCIVAL: Q. January 12th.

15

Did you attend those M and M conferences?

16

A. As I said, Mr. Percival, in

17

my direct examination I attended the September

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meetings; I was not invited to attend the January
meeting.

19

Q. Well, in any event, quite

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apart from those particular meetings I gather that

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on the morning rounds in 4A and 4B during that time

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period you would invariably attend those morning

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rounds?

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A. Correct.

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Q. And invariably learn of the deaths of the babies within a 12 hour period or if it happened on a weekend and you were not on call by the Monday morning rounds.

A. That is correct.

Q. And the number of physicians or cardiologists that were there were, what, six or seven in total?

A. The number fluctuated but about that.

Q. All right. And a number of residents and a number of fellows?

A. Correct.

Q. All right. But certainly the group of physicians that were managing the welfare of these children perhaps did not exceed 12 in total during this time period?

A. No, I would think ---

Q. At one time I mean.

A. I think that sounds perhaps a little bit on the low side. We had the residents, we had cardiac radiologists attending, about somewhere 12 to 20.

Q. Right. Dr. Rowe certainly indicated in his evidence, and I am sure you are



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familiar with it, that he was expressing continuing concern as the months progressed from September through to January. Did you share that concern as a cardiologist on these wards?

A. I think, Mr. Percival, the concern that I had, like I think Dr. Rowe and the remainder of the staff, fluctuated as the numbers dropped and then would go back up.

Q. But did you feel that there was some increasing concern as we got closer to March of 1981?

A. I think we were all concerned by what we perceive as an increased number of deaths of very sick young babies with terrible heart disease.

Q. When you talk about we, do I take it that you mean the doctors or do you mean the doctors and the nurses?

A. I think all of us.

Q. All right. Well, let's deal - you have given your concerns with respect from the eyes of a physician. Was there also concerns being expressed by the nursing teams during that same time period?

A. Well, as I said yesterday or the day before, certainly the September meetings



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through Drs. Rowe and Jedeikin I believe were
instituted at the request of nursing.

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Q. Right. Well, at some point in
time do you recall consoling at least one team of
nurses during this time period about the bad luck
that they were having because a lot of the deaths
seemed to be occurring on their particular shift?

A. I have fairly broad shoulders
and I make myself available a lot of the time to the
nurses.

Q. Well, do you recall during
that time period -- available for discussion I trust,
Doctor?

A. I wouldn't have any other
concern, would you?

Q. I see.

A. I don't remember specifically
that type of discussion.

Q. All right. Well, do you recall
having a discussion with Nurse Trayner during that
time period in the spring of 1981 that it was bad
luck and that they should be reassured that they are
doing a good job.

MR. ORTVED: When is this?

MR. PERCIVAL: Spring of 1981.



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MR. SCOTT: Perhaps he can tell us
the date, the spring is...

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THE COMMISSIONER: He may not know
the date.

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MR. PERCIVAL: I don't know the
date but I think if you look at the preliminary
hearing you will hear it.

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THE COMMISSIONER: The spring of?

10

MR. PERCIVAL: 1981.

11

THE COMMISSIONER: It wouldn't start
though officially until March 21st.

12

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MR. PERCIVAL: Quite, quite. During
the months of January and February.

14

MR. SCOTT: The winter.

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THE WITNESS: I remember,
Mr. Percival, and I believe it was from Miss Trayner,
Phyllis Trayner, that she was caring for a baby that
died. I believe that it was shortly after she had
suctioned the baby.

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MR. PERCIVAL: Q. Is that baby
Adamo?

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A. I can't remember, Mr. Percival,
the name.

23

Q. Thank you.

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A. But I remember she seemed very

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distraught and I had said to her, you know, this baby was terribly sick, I said, that sometimes suctioning can cause bradycardia and that this infant had not been doing well.

Q. Other than that can you assist me on that subject?

A. No.

Q. Do you remember during that same period of time, again, prior to March 21st, 1981 any unusual reaction of nurses to either the baby deaths or to the method in which they administered care to the babies in question?

A. Again, I was well aware through the first meeting of September, you know, the nurses were concerned by the apparent increase in deaths. I can't remember any specific nurse or any specific individual concern.

Q. Well, in particular, do you recall a particular nurse was from time to time not hesitant at all to recommend to the residents that they start an IV on the baby?

A. Yes. That came up in discussion after the events of March 21st, in my discussion.

Q. All right. Well then, I gather at that particular point you recalled something?



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A. No. I recalled that, I think it was right after Miss Nelles had been arrested.

Q. Yes.

A. The residents told me at that time that Miss Nelles had suggested on a number of these babies intravenouses be set up.

Q. All right. And do I take it that then, and I want to be fair to Miss Nelles, do I take it from that standpoint that this was not something you personally observed but something that the residents told you after the event?

A. Yes.

Q. All right.

A. I can't remember seeing in the last nine years intravenous started hardly at all by the doctors.

Q. I don't understand that, Doctor?

A. I mean, I wouldn't start the intravenouses. So that my comment was made purely what I had been told.

Q. All right. Well, do I take it that the intravenouses, are they started by the residents or the fellows or are they started by the nurses?



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A. They are started by the residents, the fellows and his intravenous team of nurses.

Q. All right. And do I take it though that before it has to be started there has to be a doctor's order?

A. Yes.

Q. Thank you. And that could be a resident or a fellow or yourself if you happened to be there?

A. Well, again, I think it is in the Hospital guidelines, Mr. Percival, doctors - at least full time staff physicians rarely write orders. So, it may be directed through one of the fellows or one of the residents or fellows.

Q. Right. One of the bits of evidence that emanated from Dr. Rowe was the fact that he at the beginning felt that he was getting an usually high number of very sick babies during this epidemic period from July of '80 to March of '81. Do you recall that evidence?

A. Yes, I do.

Q. All right. Did you share that view?

A. Yes.



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Q. In particular you shared the view because something happened in Winnipeg, did it not?

A. Yes. There were some political or some difficulties with the surgeons or the surgical situation of the Winnipeg Children's Hospital and about that time, I can't remember the exact time frame-work, a lot of the sickest children from Winnipeg were transferred here, both from the Children's Centre in Winnipeg and from the St. Boniface in Winnipeg.

Q. Are you aware of the babies that we are talking about, of the 36 babies, how many of them came from Winnipeg?

A. No, I'm not.

MR. ORTVED: On the ward?

MR. PERCIVAL: Q. The 36 that we are dealing with in Wards 4A and 4B, which I gather seems to be the numbers game at this point, Mr. Commissioner. Are you aware of that, Dr. Freedom?

A. Well, I am aware of the 36 or 38 patients you just referred to.

Q. Yes.

A. I am not certain as to how many of those were from the St. Boniface Centre or



1
2 the Children's Centre.

3 Q. Thank you. Of the 36 babies
4 that we are alluding to, whether it is 36 or 38, did
5 you have any opinion ---

6 THE COMMISSIONER: I think it is
7 36, isn't it?

8 MR. PERCIVAL: Well, the doctor said
9 38.

10 THE COMMISSIONER: Well, he said 38
11 but I think it was a mistake.

12 MR. PERCIVAL: I will stick with 36,
13 Mr. Commissioner.

14 THE COMMISSIONER: Fine.

15 THE WITNESS: I was saying what you
16 had said, 36 or 38.

17 MR. PERCIVAL: Q. All right. Let's
18 deal with the 36 babies. Do I take it that you have
19 the view that those 36 babies were certainly very
20 ill?

21 A. Yes.

22 Q. And did you have any opinion
23 before they died as to whether any of them would have
24 ever reached voting age?

25 A. That's a term I used several
times. It was my opinion that a large, or at least a



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substantial number would not have reached voting age.

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Q. Well, would you say that that number is over 90 per cent of the 36?

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A. I would say that it would be a substantial number.

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Q. All right. You can't be more explicit for me?

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A. I haven't broken it down that way. I could do that if you like.

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Q. All right. In any event, may I deal with the Estrella chart, and that is Exhibit 91.

I want to deal, if you would be good enough to assist me, Doctor, with the Estrella medical record, which is Exhibit 91. The drug orders at pages 204 and 205 for the time period immediately preceding - I'm sorry, 203, 204, 205 immediately preceding the death of Allana Miller on January 11, 1980, is that correct?

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A. Excuse me, you are talking about Estrella?

20

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Q. I'm sorry, Estrella. I have a number 203, 204, 205.

22

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A. Yes.
Q. Which appears to be doctor's orders?



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A. Yes.

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Q. Am I wrong?

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A. No, you're right.

5

Q. Thank you. They actually

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start much earlier. But those drug orders seem to

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indicate that digoxin was ordered held some time

8

on or about January 7th of 1981, and I believe that

9

is over on page 199 at the bottom of the page.

10

January 7th, 1981 at 9:45 a.m.

11

A. Yes, I see that.

12

Q. All right. May I turn then to

13

the drug administration, or medication administration

records which are pages 52 and 53 of that same

14

exhibit.

15

A. Yes.

16

Q. It would appear to indicate

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that digoxin was last given on January 6th for this

baby at 900 hours on January 6th by Susan Nelles.

18

A. Correct.

19

Q. And at 2100 hours on the

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same day by Nurse Scott.

21

A. Okay.

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Q. Do you agree with me on that,

page 52?

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A. Yes.

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Q. And do you further agree with me that it does not appear to have been given to that baby thereafter until the date of its death on January 11th, 1981; at least on the record?

A. Correct.

Q. May I turn then to the dig. levels, or digoxin levels which were ordered and apparently samples taken and records achieved, pages 158 and 159. I believe Miss Cronk alluded to those yesterday.

A. Correct.

Q. That on page 159 a sample was taken from the artery at 8:20 a.m. on January 7, 1981 with a report of a digoxin level of greater than 5.0.

A. Yes, I see that.

Q. And I believe she earlier alluded to the fact that that was later diluted and came from Dr. Ellis' book to show a level of greater than 9.4 nanograms. Do you recall that...

A. Testimony, yes.

Q. Yes, thank you. On January 8th at 10:00 a.m. a further digoxin sample was taken from the vein, this time of Baby Estrella, with the result that it was greater than 4.7.

A. Yes, I see that.



1
2 Q. And then I believe Miss Cronk
3 alluded to other evidence that would indicate that
4 on further dilution the actual reading was 7.8 nano-
5 grams?

6 A. Right.

7 Q. And then on January 9th of
8 1981 a sample taken at 9:00 a.m. from the vein gave
9 a reading of 4.7.

10 A. Yes.

11 Q. All right. And that is I
12 suggest, Doctor, what you would expect with the
13 digoxin medication having been ordered held after
14 the medication administered at 21 hours on January
15 6th, the digoxin level ante mortem would be going
16 down?

17 A. Yes.

18 Q. All right. And the last
19 antemortem sample that was taken on this baby was
20 on January 9th, '81 at 9:00 a.m. was 4.7. She did
21 not die until the early morning hours of January 11th,
22 about 40 to 46 hours later. Again, if the doctor's
23 orders were that and the administration of medication
24 was as indicated on the chart, would you agree with
25 me that had she been sampled and had not received
any other digoxin in the interval that level would be



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considerably less than 4.7?

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A. I think, depending upon her

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level of metabolism and excretion, yes.

5

Q. When we get to the pathological

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example, and I would ask you to turn to page 158,

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somebody over the top of my note on page 158 puts

8

Dr. Taylor. I don't know whether that is on the

9

original or otherwise but that's what it says, does it?

10

A. Yes, on my copy of the chart

that is what it says as well.

11

Q. And on the right hand side

12

under Service it has got PATH, and what is that for?

13

A. I would presume it means

14

pathology.

15

Q. Right. And it shows there was

16

a collection on January 11th at no estimated time.

17

Is that what it says?

18

A. I'm not sure where you're

reading.

19

Q. On the date and then hour of

20

collection it has January 11th, '81 and then it's

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got NO TIM.

22

A. Yes.

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Q. Do you agree with me that

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that means there is no indication as to when it was

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collected?

A. Correct.

Q. But it was presumably collected
by pathology?

A. Right.

Q. And the report shown on page
158 shows that it was greater than 4.7.

A. Correct.

Q. And that was apparently
reported again on January 13th at 4:48 hours, that
is 4:48 a.m. and that is again directly below the
page number 158. Do you agree with me?

A. Are you referring to results
flag and reported today?

Q. No, I am talking about
opposite Clinical Chemistry Cumulative Report, it's
got 04:48 hours - January 13th, 1981.

A. Yes, I see that.

Q. All right. And that is when
it was reported back from clinical chemistry, from
the computer.

A. Well, that is what the computer
sheet says. I don't know when that computer sheet
was distributed.

Q. I understand. Then we get



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that same sample - I'm sorry, there is at page 157
there seems to be a different sample number again
which was collected by pathology on January 11th at
no time, showed a digoxin level of 72 nanograms. Do
you agree with me?

A. Well, I am following what
you're reading, yes.

Q. Well, it says what it says?

A. That's right.

Q. All right. You correct me if
I'm wrong.

A. Well, we are reading the
same thing, so, I presume we are both on track.

Q. All right. Page 156 and 157
seems to be identical save and except some handwriting
and a circle around the words 72.

MR. ORTVED: Well, they're not
identical.

MR. PERCIVAL: With the exception of
the Cumulative Report, date and time on the right
hand corner. Page 157 shows it was reported at 4:42
hours on January 20th, '81 and it appears to be the
same sample. Is there anything different on those
pages aside from the dates on the top hand corner
and the handwriting and the circle?



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MR. ORTVED: Well, the main history number.

MR. PERCIVAL: I am talking about the sample, 1689241.

THE WITNESS: 1689241. Well, that number is the same.

MR. PERCIVAL: Q. And that's the sample number, isn't it?

A. Correct, then they have different history numbers.

Q. Well, what is the significance of that?

MR. ORTVED: Well, you asked him if it was the same.

THE WITNESS: You asked me a question.

MR. PERCIVAL: Q. Well, what is the significance of the difference?

A. Well, again, I would be concerned if they have different history numbers there is some confusion in the sample.

THE COMMISSIONER: Does the history number refer to the sample or to the patient?

THE WITNESS: I don't know.

THE COMMISSIONER: It looks to me



1
2 as though it refers to the patient but perhaps I am
3 wrong.

4 THE WITNESS: Well, I would be
5 concerned, Mr. Commissioner. The history numbers
6 that I am familiar with where it says history number,
7 one is on page 157 multiple zeros and then one has a
8 different history number. So, in response to
9 Mr. Percival, it looks like there is a different form
for some reason.

10 MR. PERCIVAL: Q. Well, in fairness,
11 you've got the same name Janice Estrella.

12 A. Well again, Mr. Percival,
13 I was just responding to your question is there a
14 difference and I am saying I can see a difference.

15 Q. In any event, the document
16 speaks for itself. I gather, can you assist
17 Mr. Commissioner, as to when you first saw these
pages?

18 A. You're talking to me?

19 Q. Yes.

20 A. I know that in discussion with
21 counsel for the Commission I was asked if I knew
22 there were two samples and I said no, I had only
heard of one.

23 Q. I understand that evidence.
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A. And I can't remember when I first saw this level of 72 in writing.

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Q. All right. Well, was it before or after the police became involved?

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A. Well, as I mentioned in my direct examination I was informed some time after the Estrella autopsy.

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Q. We are talking about seeing it in writing.

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A. I just can't recall when I first saw it.

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Q. All right, thank you.

Now, Doctor, in your evidence yesterday at pages 5443 and 5444, Volume 29, when it was reported to you a few weeks later that there was a 72 nanograms result achieved you felt that there may have been a decimal error, and I am paraphrasing this because you said I thought that baby had digoxin levels ante mortem in that same level of 7, therefore, I could have meant 7.2 instead of 72.

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A. Correct.

Q. Do I take it that that is what you meant by that evidence?

A. Yes.

Q. All right. But if digoxin had



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not been given for the four days or five days prior
to this baby's death and was going to be below 4.7
I gather you were mistaken about that impression?

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A. Well again, Mr. Percival,

I was not the ward chief, I wasn't following this
patient at the time, so, I wasn't aware of when the
last digoxin had been given, how it had been
administered and from whence it had been taken. So,
my comment was taken in isolation.

Q. All right. Now, on page 126
of the notes there are some progress notes.

THE COMMISSIONER: I'm sorry, what
page?

MR. PERCIVAL: Q. 126. I'm sorry,
there are two 126s. I guess one was supposed to be
127. I think it is the first 126 at least on mine,
Mr. Commissioner. Do you have that in front of you,
Doctor?

A. Yes, I have both pages, which
one?

Q. All right. Well, the first
page 126, it is under the heading January 10th, '81,
700 to 1900 hours.

A. Yes, I see that.

Q. All right. And it appears to



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be a note of Nurse Sanassin, is that correct?

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A. I'm not familiar with the

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last name.

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Q. All right. When in any event,

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that particular nursing note indicates that the

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IV on Allana, the intravenous on Allana ---

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THE COMMISSIONER: No, this is ---

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MR. PERCIVAL: Q. I'm sorry, Janice

Estrella went what is called interstitial.

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A. Correct.

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Q. At 1645 hours, and then went
interstitial again at 1800 hours?

A. Yes, I see that.

Q. When did you first see this page
and were aware of the fact that on the day preceding
her death that the intravenous line went interstitial?

A. I think I first saw that in the
last few weeks.

Q. In particular on page 126, the
second page, 126, it would appear that this baby went
into cardiac arrest at 2.50 a.m. on January 11th and
then was declared dead, or pronounced dead at 3.22
a.m. on the same day?

A. Yes.

Q. Is that correct?

A. Yes.

THE COMMISSIONER: I should know this,
but what is interstitial?

THE WITNESS: It is, usually the intra-
venous is directed strictly into a vein, and either
when the vein, a thrombosis, or when the needle
becomes dislodged the material will be delivered into
the subcutaneous tissue around the vein.

THE COMMISSIONER: Apparently it was
done deliberately, was it, on this baby?



F.2

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THE WITNESS: No.

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THE COMMISSIONER: Oh, that is something
that happens by accident, is it?

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THE WITNESS: All too frequently, and
that is why intravenouses frequently have to be
changed on these little babies.

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MR. PERCIVAL: Q Doctor, this question
of the intravenous becoming interstitial?

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A. Yes.

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Q With Baby Janice Estrella, that
was a subject matter of discussion between yourself
and Sergeant Warr in, I believe it was on March 22nd,
on a Sunday, or Monday the 23rd?

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A. I don't recall any specific
discussion vis-a-vis Estrella. I do remember a
discussion as to if digoxin was going to be administered
in lethal doses.

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Q Intravenously?

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A. Intravenously, what would I
consider to be the time framework for such a lethal
dose to have an effect. I think I commented at that
time well, some of these, if it goes right into the
vein I would think a very quick effect. Or, on the
other hand, if the vein goes interstitial it could
take longer. I don't recall any specific mention
vis-a-vis Estrella.



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Q I understand that, but that was discussed with the police officers in that time frame after they became involved in the Hospital?

A Correct.

Q And do you agree with me that if digoxin was being administered initially with a bolus injection, and the intravenous went interstitial, that there would be some delay factor involved in relation to the effect of digoxin on the baby?

A Yes.

Q And the delay factor might be a number of hours?

A Yes.

Q I want to take you back to your recollection about the digoxin level being ordered on Baby Estrella, and your evidence is found in Volume 29, page 5440, you gave that evidence yesterday afternoon and I gather it is reasonably fresh in your mind?

A Yes.

Q I take your evidence is, at least at this point in time, you have no recollection about ordering the digoxin level on Estrella?

A That is correct.

Q Did you know in that time period from January 1st through to June of 1981, Dr. Glen Taylor, did you know him?



F.4

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A. Yes, I met him during that time

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frame.

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Q. Did you know he was a pathological

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resident, or a resident in pathology?

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A. Yes, I did.

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Q. A slip of the tongue, Doctor, you

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will forgive me.

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A. Yes.

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Q. And did you know that insofar as

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your own residents are concerned on 4A/4B you would

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have certain cardiology residents?

13

A. Correct.

14

Q. And you would know them very well?

15

A. Correct.

16

Q. Would you know the residents in

17

pathology very well in this time period? Because I

18

gather you have some association with pathology in

19

addition to your cardiology functions?

20

A. Correct. I would perhaps have

21

more familiarity with the cardiology Fellow as you

22

might expect. The other thing is that if I recall

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the pathology residents often changed mid-year?

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Q. Yes.

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A. So that often I would know a

group by September, and by January 1st they would be

leaving and a new group would be coming on.



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Q Now your evidence is, as I understand it, that you have no recollection in ordering that digoxin level?

A That is correct.

Q You indicated, I gather you are aware at this point in time that Dr. Taylor has a different version in relation to the ordering of the digoxin level?

A Yes. I have been informed of that I believe either by the police or by the Crown.

Q And I understand Dr. Taylor is out in British Columbia, in Vancouver at the present time?

A Right.

Q I understand, Mr. Commissioner, that Mr. Lamek hopes to have Dr. Taylor give evidence, but I want to put something fairly to Dr. Freedom on that.

If Dr. Taylor, my premise is if Dr. Taylor gives evidence in these proceedings on a later occasion, to the effect that before he commenced the autopsy on Janice Estrella that he was requested, he believed, by a handwritten note on a piece of scrap paper attached to the chart, to call you. Do you have any reason to disagree with that recollection of Dr. Taylor?



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A. Well, no. I think firstly there is a sign, I am not sure it is still there in the Department of Pathology, to call Dr. Freedom and Dr. Renata Dische who used to be a cardiac pathologist until she left for another position, for all cardiac autopsies.

Q. I understand that. I am talking about a piece of paper inserted on a chart?

A. Well, I have no knowledge of that.

Q. And then if Dr. Taylor gives evidence that as a result of seeing that piece of scrap paper he either telephoned you or spoke to you in person and that you requested him to obtain a post-mortem blood sample for digoxin level, are you in a position to agree or disagree with that?

A. I have no recollection, Mr. Percival, of requesting Dr. Taylor to do so.

Q. Do you recall Dr. Taylor, and if Dr. Taylor says that he felt that a digoxin level post mortem was rather unusual, and wanted to know why you wanted it and you gave him an explanation, again are you in a position to agree or disagree with that recollection of Dr. Taylor in that conversation?

A. No. Dr. Taylor is an honourable man and I have a great respect for him as a pathology



F.7

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resident. I just don't recall, and I have seen his
testimony, I have spoken to him and I just do not
recall the conversation I had with him.

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Q. You have seen his testimony, and
in fairness Doctor, the testimony I gather that you
are referring to is the testimony that he gave on
February the 15th of 1982?

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A. Right.

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Q. In the Preliminary Hearing?

A. Correct.

Q. And if I may assist you, is it

your recollection that Dr. Taylor's evidence in the
Preliminary Hearing was very explicit, or very general
on this?

A. No. I had spoken I think after
that, or before, with Dr. Phillips to get his,
Dr. Phillips as the Head of Pathology, to try and put
all this into some framework.

Q. I understand that, but I want to
know is it your recollection, you gave evidence on
February 19th, 1982, were you present when Dr. Taylor
gave his evidence on February 15th?

A. No, I don't believe so.

Q. You read his evidence though?

A. Yes.



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Q And his evidence on February 15th,
and that is Volume 17.

A I don't have that.

THE COMMISSIONER: Nor do I.

MS. CRONK: What page, Mr. Percival?

MR. PERCIVAL: Page 112.

Q The only reference as to the reason
why he took the postmortem sample was at line 5
through to 8.

A Yes, I see that.

Q Well I am confused then. All he
says:

"Q Why did you take these particular
samples, Doctor?

"A I was requested prior to starting
the autopsy by Dr. Freedom to obtain
digoxin samples."

And then he went on to something else. I don't under-
stand what you are saying that you read other evidence
about his recollection of that telephone conversation?

A No, I read this evidence, and I
also had conversation, as I said, I can't remember
whether it was with the police or the Crown relating to
me the fact that Dr. Taylor had given them evidence
that I had requested this postmortem digoxin level.



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Q. In fairness, I gather that when Baby Janice Estrella died you would know about it the next morning?

A. Well, she died on a Saturday or a Sunday. If the pathologist called me, if I wasn't on call I would know about it that day.

Q. All right.

A. Or I would find out the following Monday.

Q. In fairness, at the Preliminary Hearing in Volume 21, Dr. Freedom, and you have read your evidence in the Preliminary Hearing?

A. Right.

Q. And you gave evidence at - very briefly that you had absolutely no recollection of this conversation with Dr. Taylor?

A. That's true.

Q. And that is as far as it went?

A. Right.

Q. That was on February 19th, 1982.

Do you recall prior to that though, in a meeting with the Crown Attorneys Mr. Magee and Mr. Wiley, on December 1st of 1981, at which conference Mr. Ortved, your counsel, was present to go over your evidence?



F.10

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A. Right.

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Q. And do you recall on that

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occasion on December 1st of 1981 saying this to

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Mr. Magee and Mr. Wiley: "The dig. level ...".

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MR. SCOTT: What are you reading from?

7

MR. PERCIVAL: I am reading from the

notes of Mr. Wiley.

8

MR. SCOTT: Can we have a copy of that?

9

MR. PERCIVAL: Sure.

10

Q. May I read it?

11

A. Yes.

12

Q. Do you have that?

13

A. I think I do.

14

MS. CRONK: We provided a copy.

15

MR. PERCIVAL: Thank you.

16

Q. Page 353 of the Crown Brief, you

say:

17

"The dig. level was taken on Estrella.

18

The resident, a Dr. Taylor, called and

19

told me about the death of Estrella. I

20

asked if Estrella was on dig. I asked

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him to get another level, there had

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been a high level ante mortem."

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Is that your recollection of what you

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told Mr. Wiley?

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F.11

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A. No.

Q. And Mr. Magee on December 1st of 1981?

A. My recollection was that I had been informed that Dr. Taylor had said that I had requested him to do all this, and I was echoing back, I don't remember this, I don't remember that Dr. Taylor had asked me to do any of this.

Q. So do I take it that the notes, if they are notes of Mr. Wiley, are in accurate in relation to what you recall on December 1st of 1981?

A. Yes, I specifically recall being somewhat surprised by this and again echoing it back, I have no recollection of that phone call.

Q. Well - or, was it this, Doctor. Do you recall wakening from a deep sleep one morning by a phone call from Dr. Taylor and mistakenly thinking that he was telling you she was ill, that you knew she had retained digoxin, had elevated levels of digoxin, and you ordered a digoxin ante mortem level, is that what occurred?

A. I remember at some point in time after all this being asked for explanations of how this could come about. I believe I did give the comment, and I can't remember, Mr. Percival, in what



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form, that it is conceivable that I got a call, that I had not known who Dr. Taylor was, that I was in a sleep and that I responded in more of a clinical fashion thinking that the child had sustained a clinical problem and had said what I did.

Q. Dr. Freedom, maybe I can assist you, do you recall giving an interview to one Nancy Hawkins of the CBC Metro Morning in the summer of 1982, after the Preliminary, about these very events?

A. Yes, I think she asked me for an explanation, for a possible explanation.

Q. I have a transcript, I have the tape, may I enter it, please? Did you hear the interview?

A. No.

Q. Would you like to hear it?

A. Sure.

THE COMMISSIONER: How are you going to manage that?

MR. SCOTT: Surely, Mr. Commissioner, if we all have transcripts it is highly theatrical to play it.

MR. PERCIVAL: My friend would object, where is the transcript, where is the tape.

MR. SCOTT: I am asking for a transcript



F.13

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and I understand they are being handed out right at
this very minute by your clerk, or Junior.

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THE COMMISSIONER: Well, it surely
can't do any harm to have it played. It may not do
any good, but if you think it will ---

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MR. PERCIVAL: It sounds like him
anyway, Mr. Commissioner.

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THE COMMISSIONER: I don't think he is
denying it.

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MR. PERCIVAL: Well, I don't know, I
don't know.

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THE COMMISSIONER: Well, all right, I
don't think it would do any harm however dramatic it
may be, so you carry on.

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--- [Tape recording played]

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"Male Reporter: A leading Cardiologist
at Toronto's Hospital for Sick Children
says a hospital test that led to the
investigation of several infant deaths
was initially ordered on a dead baby
by accident. Dr. Robert Freedom says
when he ordered a routine test of the
digoxin level in Baby Janice Estrella,
he thought she was alive. The baby is
one of four known to have died from an



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"overdose of the heart drug. With a report here is Nancy Hawkins.

"NANCY HAWKINS: At the time of Janice Estrella's death in January 1981, tests of digoxin levels were routinely done on infant patients in the Hospital's Cardiac Unit, but they were never performed on babies who had died. In an interview Dr. Freedom described the fluke which led to the discovery of the baby's overdose. Dr. Freedom says he was not directly responsible for Janice Estrella, although he was one of seven cardiologists on call for emergency. He recalled being awakened from a deep sleep early one morning by a call from a Dr. Taylor at the Hospital, in his semi-conscious state Dr. Freedom mistakenly thought Dr. Taylor was telling him that little Janice Estrella was very ill again. Since she had tended to retain digoxin in the past, Dr. Freedom ordered that her levels be checked.



F.15

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"DR. FREEDOM: It was only two weeks later when I met Dr. Taylor and found out that Estrella had died when I realized that I had actually ordered a digoxin level post mortem.

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"NANCY HAWKINS: So it's only really inadvertently that this was discovered?

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"DR. FREEDOM: That's correct.

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"NANCY HAWKINS: The autopsy result led to the grim discovery that the baby's body had 32 times the normal level of digoxin. However, it was only after another baby was found to have died of a similar overdose two months later that a police investigation was ordered. Since then digoxin levels have been tested after all infant deaths in the Cardiac Unit."

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MR. PERCIVAL: Can we have that

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transcript marked as the next exhibit and I will mark the tape if you wish, Mr. Commissioner, if you have no objection?

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THE COMMISSIONER: I don't know, Mr.

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Scott may want it, I don't know, I don't particularly. I don't think we need it, there doesn't seem to have been any change.

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F.16

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MR. PERCIVAL: With respect,

Mr. Commissioner, I think there is no change from
the tape to the transcript.

THE COMMISSIONER: No, no, that's right.

MR. PERCIVAL: Yes.

--- EXHIBIT NO. 170: Tape of interview held
with Ms. Nancy Hawkins,
CBC Metro Morning and
Dr. Robert Freedom.

Mr. Scott always thinks it is funny
when his client is being cross-examined.

MS. SYMES: Can you help me please and
tell me the date of the interview?

MR. PERCIVAL: I am told it is June
or July of 1982.

MS. SYMES: Thank you very much.

MR. PERCIVAL: Q. Is that your
recollection, was it after the Preliminary Hearing?

A. I can't remember, I know it was
some months, or a year later.

Q. It was after the Preliminary
Hearing?

A. I just can't recall the time frame.

THE COMMISSIONER: It was a year later
than what?

THE WITNESS: It was certainly after I



F.17

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had been informed about the digoxin level of 1972

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and I can't remember when I gave that interview.

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Q In any event, do I take it in

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fairness, Dr. Freedom, that your confusion or lack of

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recollection may in part have been played by the

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number of many babies that you looked after; the

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number of many conversations that you must have had

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and still continue to have with residents, Fellows

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and other physicians on these wards during this time
period?

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A Would you repeat that?

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Q Well, you seem to be somewhat

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confused and you have some difficulty recalling. I

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am just saying to you, do I take it that is because

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you have had so many different conversations with so

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many different people, and have looked after so many
different babies?

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A I would say, Mr. Percival, that

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interview was taken a little bit out of context. I

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told that reporter that I didn't remember ever having

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a conversation with Dr. Taylor. She asked me: "How

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could that come about?" and I gave one possible
explanation.

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Q Do I take it when it comes down

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to the bottom line, Dr. Freedom, that because of your

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F.18

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lack of recollection of the conversation with

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Dr. Taylor, that if Dr. Taylor gives evidence you

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would likely defer to the evidence he gives as to the

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nature of that conversation that he had with you that

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brought about the sampling from the Estrella baby?

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A. Yes.

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Q. Thank you.

Doctor, I was trying to find out something about your activities, and as I understood your evidence that you had a tragedy in your family and you went to California and that you returned on some date in March of 1981?

A. Right.

Q. Can you remember when that was?

A. I believe I returned on Thursday, March 12th.

Q. All right. And you were then away throughout the time period when Kevin Pacsai died?

A. Correct.

Q. That week immediately subsequent to March 12th, 1981, you were informed or I think you used the terminology you heard rumblings about the elevated digoxin level on Baby Pacsai?

A. Yes, late that following week.

Q. That would be March 18th or 19th?

A. Right.

Q. Wednesday, Thursday?

A. Late that week.

Q. All right.

A. I can't remember more specifically.



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Q. All right. And you have given evidence yesterday that having heard those rumblings or heard about those elevated digoxin postmortem levels that you did not think of the conversation you had with Dr. Taylor?

A. I believe that is correct, yes.

Q. And Estrella?

A. Yes.

Q. And the 72 nanograms?

A. Right.

Q. All right. Do I take it that the rumblings that you heard with respect to the elevated levels of digoxin involving baby Pacsai, you must have heard that from people like Dr. Rowe, Dr. Fowler and your residents.

A. I can't remember the exact source but I do remember hearing that baby Pacsai had an elevated digoxin level.

Q. But you knew also that Dr. Tepperman was involved in relation to Pacsai by the time you heard of those elevated digoxin levels too, did you not?

A. No, I wasn't sure at which time any of the coroners had been informed or any specific



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Q. Well, do I take it that under the circumstances -- did you not see Dr. Tepperman in your hospital?

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A. Well, it is a large hospital. I can't remember -- I have seen Dr. Tepperman on numerous occasions over the years. I just can't remember when I saw him.

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Q. All right. What I want to know, in that time period, March 1981, is the fact that the coroner is in your baby wards something usual or unusual?

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A. Well, again it is -- the coroner has been called for numerous cases, as you know.

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If I am not the ward chief, if I am seeing patients or in the catheter lab, Mr. Percival, I may not know he is there even though he has been invited by one of the staff.

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Q. Do I take it that when you heard of the rumblings about Pacsai, did you know at that point that the coroner was involved?

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A. I can't remember specifically either way.

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Q. All right.

A. I presume the coroner was or a



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3 coroner was involved.

4
5 Q. When did you really -- are you able
6 to assist the Commission here as to when you knew there
7 was a coroner involved and was actively involved in
8 looking at some babies in wards 4-A and 4-B? What
9 point in time?

10 A. Well, again, I called the coroner
11 myself for Velasquez.

12 Q. No, I'm talking within the month
13 of March after you returned.

14 A. I believe at some time late --
15 some time Saturday morning I spoke to Dr. Rowe.

16 Q. All right.

17 A. I believe, and he told me there
18 was a meeting with the coroner.

19 Q. A meeting with the coroner you
20 were told that Saturday morning, early Saturday
21 morning, was it? Was it before you did the Cook
22 catheterization?

23 A. I can't remember the time frame-
24 work.

25 Q. All right. In any event, you
knew there was going to be a meeting with the chief
coroner, did you not?

A. No, I didn't know who it was. I



1
2
3 just heard there was a meeting with the coroner's
4 office.

5
6 Q. At the coroner's office?

7 A. No, a meeting with the coroner.

8 Q. I see. Did you know where it
9 was going to be?

10 A. No, I wasn't invited.

11 Q. What was your knowledge at that
12 point, that they were going to discuss what?

13 A. I had no knowledge. I heard
14 subsequently they were going to discuss Pacsai and
15 Estrella.

16 Q. What I want to know is what you
17 knew that morning, on the Saturday morning did you know
18 that they were going to discuss Pacsai and Estrella or
19 did Dr. Rowe or Fowler give you any more information
20 other than the fact they were going to have a meeting
21 with the coroner?

22 A. I think that that time just a
23 meeting with the coroner.

24 I had catheters to do so again I hadn't
25 been invited and I didn't inquire.

Q. All right. Now, I want to,
Doctor, if I may, take you through your evidence at the
preliminary hearing.



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A. Yes.

Q. And I do believe that you probably have read your evidence, have you?

A. Yes.

Q. Have you read it on more than one occasion?

A. I looked at it certainly in more detail getting ready for this session. I had not paid much attention to it earlier.

Q. Do you have it in front of you? May I assist you? Do you have it in its entirety?

A. I think so. Why don't we start and if I don't, I will ask for your help.

MR. PERCIVAL: Perhaps these are the relevant pages. They start at Page 20, Mr. Commissioner, of Volume 21 of the preliminary hearing which took place on February 9th of 1982.

THE COMMISSIONER: Page 20 of Volume 20?

MR. PERCIVAL: Volume 21.

THE COMMISSIONER: Date, again, please?

MR. PERCIVAL: February 19th of 1982, Mr. Commissioner.

THE COMMISSIONER: All right. Will it help to make them an exhibit or not because obviously we all have them.



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MR. PERCIVAL: I would think it would
help.

4

THE COMMISSIONER: All right.

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MR. PERCIVAL: Because I intend to go
through it exhaustively.

7

8

THE COMMISSIONER: What number, is it
171?

9

THE REGISTRAR: Yes.

10

---EXHIBIT 171: Copy of transcript of preliminary
hearing, Volume 21, February 19, 1982.

11

12

MR. PERCIVAL: These are pages, for the
purpose of the record, Mr. Commissioner, if that may
help, these are pages 20 to 37 and 54 of the same...

14

Q. Do you have that, Doctor?

15

16

A. I don't believe so. I have some-
thing but it has different page numbers. Maybe I could
get a copy?

17

18

Q. Yes, by all means. I have an
extra one here that will assist and is identical to the
exhibit.

19

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MR. OLAH: Excuse me, Mr. Commissioner.

21

THE COMMISSIONER: Yes.

22

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MR. OLAH: Have we marked the transcript
yet as an exhibit?

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THE COMMISSIONER: Yes, we were, we just now
have 171.

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5

MR. OLAH: This is the transcript from
the CBC interview.

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THE COMMISSIONER: Yes, that is 170.

7

8

MR. PERCIVAL: Q. From Pages 24 to
Page 30 --

9

A. Yes.

10

11

Q. -- you dealt with the death of
Allana Miller and your activities on Thursday, March
19th, Friday, March 20th and then Saturday, March 21st.

12

A. Right.

13

14

15

Q. And starting at Page 24 I want
you to agree or disagree with me with reference to this
and I will give you the references if you wish, please.

16

17

That evidence collectively indicates that
you ordered the dig. level and the dig. dose held on
Thursday night, March 19th?

18

A. Correct.

19

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22

Q. That late on March 19th or early
on Friday, March 20th when the digoxin level was
reported as 0.6, that you felt on the Friday, March
20th, that you should also hold it on Friday night.

23

A. Correct.

24

25

Q. But despite your views a resident



1
2
3 apparently ordered the digoxin administration of
4 .032 milligrams at 3 p.m. on Friday, March 20th.

5 A. I would say it wasn't necessarily
6 despite my views. Dr. Fowler is ward chief.

7 O. I understand.

8 A. Overseeing the case of this child.

9 Q. Right. In any event, I am ac-
10 curate in that the resident ordered that for this
11 child?

12 A. Yes.

13 O. Thank you. That according to the
14 Miller records that that apparent dosage of digoxin was
15 administered by Nurse Susan Nelles at 9 p.m. on
16 Friday, March 20th.

17 A. I have no record of who
18 administered it.

19 Q. Well, will you take that from
20 me --

21 A. Yes.

22 Q. --that that is in the medical
23 record?

24 A. Yes.

25 Q. And that the digoxin administra-
tion was ordered held by the resident at 2:30 a.m. on
Saturday, the 21st?



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A. Yes.

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Q. All right. Would you agree with me that according to your evidence at the preliminary hearing that you last saw Allana Miller between 6:00 and 7:30 p.m. on Friday evening, March 20th?

7

A. Yes.

8

Q. And then went off duty?

9

A. Yes.

10

Well, I went off duty other than the fact I was on call for catheters for that weekend.

11

12

Q. I understand, and I will come to that.

13

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16

And you were first apprised of the death of Allana Miller when Dr. Schaffer called you at about three to four a.m. on the morning of Saturday, March 21st?

17

A. Yes, that is my recollection.

18

19

Q. Right. That you then came to the hospital about two or three hours later?

20

A. Right.

21

Q. Which would get you to the hospital somewhere around six or seven a.m.?

22

A. Right.

23

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Q. Right. Would you also agree with me that at Page 29, Line 4 you were asked this question--

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11
1
2
3 sorry, starting at Line 2 and ending at Line 8 were
4 you asked this question and gave this answer:

5 "Q. All right. Did you become aware
6 of the digoxin reading with respect to
7 Allana Miller?

8 A. Yes, on Saturday.

9 Q. On Saturday? Do you recall what
10 time that would be, Dr. Freedom?

11 A. I believe it was early to mid-
12 afternoon."

13 A. Yes, and I was clearly in error.

14 Q. All right. I gather it is an
15 error as a result of other evidence that you have heard
16 subsequent to February 19th, 1982?

17 A. No, I think it was -- I wouldn't
18 say it was in reference to evidence I had heard. It was
19 just that I didn't have the chronology correct at that
20 time.

21 Q. All right.

22 A. I heard it later on Saturday
23 evening.

24 Q. All right. What I am getting at
25 is this: when subsequent to February 19th, 1982 did
you feel that you had heard about it on Saturday
evening, as opposed to early or mid-afternoon?



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A. I just can't recall.

Q. All right. In any event, your evidence continues at Page 29 that you had called in about another patient and you were informed that the level was "sky high"?

A. Right.

Q. And again, is that your evidence on February 19th, 1982?

A. Yes. I called in late that Saturday evening.

Q. Well, in fairness, Doctor, carrying on with my previous readings, on Page 29, Line 9:

"Q. All right. Before you left the baby or at the time you left the baby on the Friday night, while you described the surgery that you thought she would require, was her death expected so far as you were concerned?

A. No.

Q. Why do you say that?

A. I felt the child had improved. The rhythm disturbance while present was less erratic and the baby looked considerably more comfortable than early



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Friday morning.

Q. All right. Now, you were advised of this digoxin level that had been obtained post mortem from Allana Miller and what did you do as a result of learning that?

A. I'm not sure I was informed. I remember I was not on call that weekend but I called in to find out about another patient and I had heard that Allana Miller's level was sky high."

A. Yes.

Q. Do you recall giving that evidence on February 19th, 1982?

A. Yes.

Q. Was that the truth?

A. I'm sorry?

Q. Was that the truth?

A. I remember calling in that evening. I was not on call other than for emergency catheter procedures.

Q. Do you agree with me that on Page 29 the only reference to timing is early to mid-afternoon on that page?

A. Correct.



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Q. Thank you. Now, in fairness, Doctor, that Saturday morning quite apart from having been called by your resident at three or four o'clock and coming in at six to seven a.m.--

A. Yes.

Q. -- you came in and were made aware then of baby Allana Miller's death, and I think you told Ms. Cronk that you participated somewhat in relation to the gross autopsy?

A. Correct.

Q. And then because you were on call you participated in two heart catheterizations, one of which was Justin Cook?

A. Correct.

Q. And that occurred at about 10:30 a.m. that morning of Saturday, March 21st?

A. I can't remember, but as I said, Mr. Percival, we did two catheter studies on Saturday. I can't remember which one I did first.

Q. Well, then, let me refresh your recollection. Look at Page 30, if you would, Doctor, Line 7 to Line 11:

"Q. All right. Did you do a catheter study on Justin Cook?

A. Yes, I did.



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Q. When did you do that?

A. I believe it was about 10:30 on
Saturday morning."

Again does that refresh your recollection and is that
the truth?

A. Again I didn't have all my
notes in front of me. I would have to check the
exact timing of this catheter.

Q. But is that the approximate time?

A. I would just have to check my
notes, Mr. Percival.

Q. Well --

A. Again --

Q. Could you let us know by Monday?
Is it going to take you longer than over the lunch
hour?

A. I would hope not. Perhaps if
the chart is here I could look at the lunch break.

Q. All right. Thank you.

You told Ms. Cronk that in any event
at the time you did the heart catheterization of Justin
Cook that morning of Saturday, March 1st, that you felt
in view of anatomical anomalies presented by this baby
that digoxin, if anything, was certainly contraindicated?

A. Correct.



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Q. And it was probably something like inderol which is the direct antithesis of digoxin which would be more beneficial to this child?

A. Correct.

Q. You did that heart catheterization with Dr. Jedeikin?

A. Jedeikin, correct.

Q. Yes. I put it to you, Doctor, that during the course of the heart catheterization of Justin Cook on the morning of Saturday, March 21st, that you said to Dr. Jedeikin if this baby dies from digoxin we have a murderer in our midst?

A. I think that is incorrect.

My recollection is that I spoke to Dr. Jedeikin about the Cook catheter and how the baby was doing later Saturday evening.

Q. I am talking about during the heart catheterization did you in fact say that?

A. No, I said it, I believe my recollection is later that evening in speaking to Dr. Jedeikin as to how the baby Cook had tolerated the catheter study.

Q. Well, do I take it then that then the whole concept of whether there was a murderer in your midst then came to a head, at least in your present



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3 recollection, in the evening of Saturday, March 21st?

4 A. Yes.

5 Q. And that at least on your present
6 evidence is in consequence of learning the coroner was
7 involved with Pacsai, Estrella and Miller, and that
8 there was elevated digoxin levels post mortem in all
9 three?

10 A. Certainly on Saturday evening I
11 had been informed or was informed about a high level on
12 Miller. I can't recollect if I was told at the time
13 what the level was, but I certainly had remembered
14 that Miller had a low level on Friday and I was very
15 concerned.

16 Q. Well, more importantly you did
17 not expect Allana Miller to die overnight and she
18 certainly did.

19 A. Well, again when I saw her on
20 Friday evening she looked more comfortable, and I was
21 disappointed that she had died.

22 Q. Well, do I take it then that whether
23 or not it was Saturday morning or Saturday evening or
24 Saturday evening, the matter of unusual if not suspicious
25 if not malevolent activities occurring in your hospital
was clearly in your mind?

A. Certainly by late that Saturday



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evening, yes.

Q. Right. And you knew the coroner was involved and that there had been a meeting that afternoon?

A. I knew that there was a meeting with the coroner, yes, that afternoon.

Q. Did you know that the police were involved that evening?

A. I was certain that once I was told about this level of digoxin the police were going to be involved.

Q. Right.

THE COMMISSIONER: You didn't complete the answer or at least I haven't a note here about whether you remember sort of saying to Dr. Jedeikin that night that if this baby dies we have a murderer in our midst.

THE WITNESS: No, Mr. Commissioner -- I can't recall whether it was precisely to Jedeikin or over the phone that I sort of made a comment --

THE COMMISSIONER: But you did to someone I take it?

THE WITNESS: Yes.

THE COMMISSIONER: And you think that was the night of Saturday, March 21st?



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THE WITNESS: Saturday, March 21st.

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MR. PERCIVAL: Q. In particular with respect to baby Justin Cook you knew, having done the catheterization on Saturday, March 21st, that the baby was going to be operated on the following day?

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A. Correct, and I know that when I called in late that evening I heard that he had had a severe cyanotic spell.

10

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Q. All right. You saw the baby about an hour after you finished the catheter study and the baby looked well and very stable, didn't you?

13

14

A. Correct.

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Q. That is at the top of Page 32 of your evidence at the preliminary hearing.

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A. Yes.

Q. So the baby, Justin Cook, looked well and was very stable at that time which was between 2:00 and 2:30 in the afternoon at the latest, again, according to your evidence.

23

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A. Right.

Q. And I understand that it was either -- it was Sunday that you found out about baby Cook dying?

A. Yes.

Q. When on Sunday?



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A. I think it was in the early morning or later that morning.

4

Q. All right. That was March 22nd?

5

A. Yes.

6

7

Q. Right. Do I take it that having then learned of the death of baby Justin Cook that you were surprised, disappointed if not saddened as a result of the death of baby Miller on Friday, March 21st and baby Cook on Sunday, March 22nd?

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A. I was sickened.

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Q. Thank you. Now, on Sunday,
March 22nd you were made aware of the elevated
digoxin postmortem levels for Justin Cook which were
then 78. Is your answer yes, Doctor?

A. Yes. I can't remember the
exact time framework.

Q. All right.

A. But I do remember being told
it was very high.

Q. Estrella was 72, to your
knowledge at that point?

A. Yes.

Q. Miller was 72.

A. Yes.

Q. To your knowledge at that
point?

A. I can't remember if I had
the number but I just remember it was very high.

Q. Pacsai was 25 to your knowledge
at that point?

A. Yes.

Q. Is there any way any of those
levels in your opinion would have been administered
or obtained by accident?

A. Are you asking me as of 1983,



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Mr. Percival, or as of 1981?

3

Q. How about February 19th, 1982

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when you gave evidence under oath?

5

A. I thought that those levels

6

had to have been achieved by some advertent or

7

inadvertent overdose.

8

Q. How about intentional, does

that mean advertent or inadvertent?

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A. Yes.

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Q. Which is it?

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A. Either way.

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THE COMMISSIONER: Intentional?

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THE WITNESS: Intentional.

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MR. PERCIVAL: All right.

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THE COMMISSIONER: Well, at least,

I take a stand on that.

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MR. PERCIVAL: I understand that,

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Mr. Commissioner. I think your point is well taken

18

and I think we understand it as well.

19

Q. That in any event on February 19th of

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1982 you were asked this very question were you not,

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Doctor?

A. Yes.

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Q. Page 33, line 25:

23

"Is there any way any of those levels

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"in your opinion could have been
administered or obtained by accident?

A. No.

Q. Why do you say that?

A. The levels that were achieved
were so high that I just, I think it is
impossible for routine administration
of digoxin in the doses prescribed to
have achieved levels of the type that
we've seen here."

A. I would certainly think that
was a fair statement that I made based on my knowledge
back at that time.

Q. February 19th, 1982?

A. Right.

Q. Now, do I take it that certainly
when the police came into the Hospital and you spoke
to them, you were 100 per cent convinced that murder
had been committed in the Hospital?

A. Yes, I was.

Q. All right. And that I gather
from your sworn evidence on February 19th, 1982 you
still held that opinion?

A. Yes.

Q. Now, do I take it there was a



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slight variation this morning, and I think you used the term 'it shaded your concern. I didn't get it down quite correctly but I think you used the word shaded?

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A. I can't remember which context that was.

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Q. All right, but do I take it that this was a direct result of your involvement with the Murphy inquest in May of 1983?

10

A. Yes, certainly.

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Q. All right. And that's the thing, the evidence there causes you now to have some concern about that opinion that you held when you first spoke to the police and that opinion that you held at the time you gave sworn evidence in the preliminary hearing.

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A. Well certainly, Mr. Percival, I felt very strongly back in March of 1981 when I gave this evidence that there had been murder.

19

Q. Yes.

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A. Over the subsequent year and a half, not just the Murphy inquest, but my reading, my ongoing conversations with our pharmacologists have shaded my opinions as well.

23

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Q. Do I take it though, Doctor,



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it may shade your views with respect to Estrella, and
does it?

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A. And Pacsai.

5

Q. And Pacsai.

6

A. And Miller perhaps.

7

Q. And Miller. I gather there

8

is some doubt in your mind about whether or not you
have a shaded concern about that?

9

A. Well, I think again, as you

10

know as well as I, there was a lot of evidence about

11

the pharmacokinetics of digoxin post mortem and

12

tissue contamination.

13

Q. Do I take it you will again

14

like Dr. Rowe did defer to experts in that field

15

which we hopefully will subsequently hear in these

16

Commission proceedings?

17

A. Yes.

18

Q. But whatever your shaded

19

concern may be, Justin Cook, do you still have the
present opinion that that baby was murdered?

20

A. I still have the opinion that

21

he died as an overdose of digoxin.

22

Q. Intentionally administered?

23

A. I would be very concerned if

24

that were the truth.

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Q. What do you mean you are very concerned, you are very sure?

4

A. Well, no one is sure I guess.

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Q. I gather you have the same problem that Dr. Rowe has, it's difficult ---

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MR. SCOTT: Mr. Commissioner, if I may interrupt. With the greatest of respect it is not a problem, it is the fact that we are being asked to express an opinion about which ---

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MR. PERCIVAL: I would like to finish my question and tell him what the problem is.

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MR. SCOTT: No, no, I am entitled to make an objection under the rules and I think Mr. Percival will just have to live with that, whether my objection is right or wrong. If the question about which is asked, does he have an opinion, now, he has given his medical opinion and then Mr. Percival goes on to ask him what he believes. In my respectful submission this is a matter for the Inquiry to decide.

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THE COMMISSIONER: Yes, yes. But I think all Mr. Percival was trying to do was to untangle the language. The language was a little difficult, it was, I would be greatly concerned about that and Mr. Percival didn't quite understand what



C.

1
2 that meant, whether it meant that he did believe or
3 that he did not believe that the child was -- I am
4 not as concerned as other people might be about the
5 Doctor's present opinion based upon his knowledge of
6 pharmacology as to whether he thinks the baby was
7 killed or not. I think that is something I am going
8 to have to determine and I think I will pay more
9 attention to the pharmacologists.

10 MR. SCOTT: Well, perhaps I misunder-
11 stood the question.

12 THE COMMISSIONER: Well, I thought
13 that all that Mr. Percival was trying to do was to
14 find out what he was saying and what his opinion was.
15 We seem to have been taking the opinions of all of
16 the doctors at various times, what they believe,
17 believed then or believed at a different time and
18 believe now. It isn't that vital but that is what
19 we have been doing.

20 MR. SCOTT: Well, perhaps just to
21 emphasize, the issue that you have to decide isn't
22 going to be determined by counting heads as to who
23 believed what, it is going to be determined by
24 evidence of fact one way or the other and my objection
25 extends so far that ---

THE COMMISSIONER: Unfortunately it



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may not be fact, it may have to be opinions.

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MR. SCOTT: Well, that will by

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yours.

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THE COMMISSIONER: It will be mine

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based in part upon others.

7

Yes. Now, carry on if you can remember
what the question was.

8

MR. PERCIVAL: That is always the

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problem.

10

Q. Doctor, you used that

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expression and I think the Commissioner alluded to it
a few moments ago that I would have concern about it.

12

13

What did you mean by that?

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A. I would share the concern that

15

this child may have been murdered.

16

Q. And that is a difficult concept

17

I gather as a doctor in the Hospital for Sick
Children to believe occurs?

18

A. I think it is a difficult

19

decision or concept for most people to accept that

20

children are being murdered in a hospital.

21

Q. I understand. Now, Doctor,

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can I get back to the question of contamination?

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A. Yes.

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Q. You gave evidence at page 5449

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yesterday at Volume 29 of your proceedings that your view of what Dr. Taylor told you was somewhat lost in a perception of what you believed occurred in the taking of the sample. I don't know whether I say it correctly, I could give it to you but it goes on for about three pages. Do I accurately paraphrase that?

A. Well, I had no idea how we took the sample.

Q. That is what I was getting at. Do I take it then that he did not tell you how he took the sample?

A. That is correct.

Q. Nor did you enquire?

A. That is correct.

Q. Right. So, do I take it that if Dr. Taylor's evidence is that he took it one from the vein and one from the pelvic cavity your allusion to a hot knife cauterizing the heart and taking the blood from the heart really does not apply?

A. No, I don't think ---

MR. ORTVED: I think that answer was in response to how he came to a view as to that sample, not how it was done.

MR. PERCIVAL: May I continue,



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Mr. Commissioner?

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THE COMMISSIONER: Well, I don't understand, Mr. Ortved, what is your complaint about the question?

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MR. ORTVED: Well, I don't think that's a fair question. I think if he put to Dr. Freedom on the basis that is what he was saying was done and Dr. Freedom's answer yesterday, if you want to read through all of 5449 was to explain his rationale for coming to the view that it was perhaps not reliable.

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THE COMMISSIONER: Yes, but all that Mr. Percival is doing is to show that his concern need not have been present, if in fact the sample was taken in a manner that Dr. Taylor said it was, isn't that all?

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MR. ORTVED: Well, I think it is a question of Dr. Freedom's state of mind at the time that's in issue and that is not what Mr. Percival's question is directed at.

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THE COMMISSIONER: Well, am I right?

MR. PERCIVAL: Yes.

THE COMMISSIONER: That all you want to know is whether his concern as it has developed was a valid concern or not.

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MR. PERCIVAL: Yes. Yes, that's



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right, that's all.

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THE COMMISSIONER: Well, I think if
you can remember the question, Dr. Freedom, you can
answer it.

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THE WITNESS: Yes. I would still
have concerns, Mr. Percival, that if blood were taken
from the pelvic gutter with tissue juices, tissues
from the heart, stomach contents, that that would be
a contaminated sample. Again ---

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MR. PERCIVAL: Q. Is that your
present opinion or would that have been your opinion
in January of 1981?

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MR. ORTVED: I don't think he
finished his answer before you interrupted him.

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MR. PERCIVAL: I want to know.
There seems to me there are some variations,
Mr. Commissioner.

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THE WITNESS: I think, you know,
life is a series of learning processes, Mr. Percival.
It is hard for me to put into perspective over the
past two and a half years what one learns about
digoxin but I would certainly ---

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THE COMMISSIONER: Well, I'm getting
a little lost now too. Do I understand that
Dr. Taylor had somewhere said ---



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MR. PERCIVAL: Yes.

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THE COMMISSIONER: This was taken.

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MR. PERCIVAL: Yes.

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THE COMMISSIONER: Could we put
that - that I think is what you are trying to say.

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MR. PERCIVAL: It was taken from the
vein of the leg and from the pelvic cavity.

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THE COMMISSIONER: Yes.

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MR. PERCIVAL: Q. And my point is
this. In January of 1981 had you known that, would
you have been concerned about contamination?

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A. Yes.

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THE COMMISSIONER: Yes. And you
would, because of the pelvic cavity, is that right?

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THE WITNESS: Correct.

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Q. What about blood from the vein
in the leg?

A. I would have to know how it was
obtained.

Q. All right. Do I take it that at
some point in time you actually learned how this was
taken?

A. Just very recently in reading
Dr. Taylor's - or the evidence that was given to me.

Q. All right. Well, what I'm
getting at is this, and I guess it comes down to this,
did you mention contamination of the post mortem level
of 72 to the police officers in the four or five days
they were in the Hospital prior to the charges being
laid?

MR. SCOTT: Well now, Mr. Commissioner,
doesn't this relate, as much of this does, to the
phase 2. If we're going to have - if we are going to
be expected to ---

THE COMMISSIONER: It may relate as
much but surely it does relate now because if it were
taken, whether it was taken from contaminated blood
or not it is surely a matter of concern to me as to
whether or not the reading is valid.

MR. SCOTT: Well, he has said that he



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found out in the last few months from reading

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Dr. Taylor's evidence how it was taken.

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THE COMMISSIONER: Yes.

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MR. SCOTT: Now, that is perfectly

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proper, no complaint as to when he found out. But if

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my friend is going to get into that, he is going to

8

say did you tell the police that.

9

THE COMMISSIONER: Yes.

10

MR. SCOTT: On his own answer he

obviously ---

11

THE COMMISSIONER: He says this question

12

relates to credibility I would think.

13

MR. PERCIVAL: Yes, quite, Mr. Commissioner

14

THE COMMISSIONER: I think that is all

15

it is and it is credibility as to whether or not this
was a contaminated sample.

16

MR. SCOTT: Well, Mr. Commissioner,

17

let's follow it through. He said he was concerned

18

about contamination. Mr. Percival has established

19

from him already that he didn't hear how Dr. Taylor

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did it until a couple of months ago. Now, isn't that

21

the end of it. To ask him whether he referred the

22

police to the way Dr. Taylor did it a year before he

heard from Dr. Taylor how it was done.

23

THE COMMISSIONER: Well, if he didn't

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2 refer it to the police it may well be that at that
3 time he did not have any idea of contamination and
4 he said that he has. So, the question seems to me
5 to be valid for that purpose and perhaps for that
6 purpose only. But at any rate, for that purpose I
will allow it.

7
8 MR. PERCIVAL: Q. Can you assist me,
9 Dr. Freedom, on that. Do you recall ever mentioning
10 contaminated samples on either of any of these four
11 children to the investigating police officers up until
the charges were laid on March 25th of 1981?

12 A. I can't recollect specifically
13 either way.

14 Q. Thank you. If their evidence is
15 that that was not mentioned would you be prepared to
accept it?

16 MR. SCOTT: Mr. Commissioner, with the
17 greatest of respect. The question was permitted on
18 the grounds of credibility. My friend is eliciting
19 this information for another purpose. Now, if we are
20 going to run these two phases together I want to know
about it so I can conduct a full examination.

21 THE COMMISSIONER: Wait, wait, wait.
22 Whether it was contaminated or not is surely an issue
23 with which I am interested in this phase of the
24 examination.

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MR. SCOTT: But he's got his answer
and now he's going on.

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THE COMMISSIONER: Well, if the answer
is, perhaps if the answer is that he concedes he has
no evidence that it was contaminated and that ---

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MR. SCOTT: He's given his answer and
my friend now proceeds with the next question which
illustrates why he really wanted to ask the first
one; not for credibility but rather to lay a foundation
for a case that he is going to make in phase 2.

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He said yesterday that that is what he
was going to do today when you make your ruling. Now,
if that is going to be done, if these phases are
going to be allowed to be rolled together to meet the
needs of one counsel, we are all going to have to
know that because we have very different kinds of
questions that are appropriate in phase 2 and we will
ask them now if that is the way it is going to be
done.

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THE COMMISSIONER: Well, Mr. Lamek
laid down the law to us at the beginning.

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MR. SCOTT: And the law has to be
applied in my respectful submission to all of us
equally.



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THE COMMISSIONER: That's true, but I
find ---

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MR. PERCIVAL: Mr. Commissioner, I
didn't bring up contaminated samples, the doctor did.

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6

MR. SCOTT: No, you brought up the
police investigation.

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MR. PERCIVAL: May I finish?

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THE COMMISSIONER: Yes. I am going to
allow the question with respect to contamination
because it seems to me that it is relevant to this
issue. If it is also relevant to some other issue, at
least, some other phase of the Inquiry, I will do my
best to forget about it at least until we get to that.
Now, that doesn't mean ---

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15

MR. PERCIVAL: That's the end of the
question anyway.

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THE COMMISSIONER: --- except for
Mr. Scott I am not going to pale before it. We are
still going to follow the Lamak rules as long as we can.

19

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MR. PERCIVAL: Thank you.

21

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Q. Doctor, can you help me?

A. I certainly remember mentioning
to Dr. Taylor when he said to me several weeks later ---

Q. Several weeks later as to what?

A. Late in January of 1981 when he



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mentioned to me about this level of 72 in Estrella.

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I said, geeze, it must be a decimal or a calculation

4

or an artifact.

5

Now, the term artifact I was thinking

6

of was as I suggested yesterday, that if the heart

7

had been cauterized, a needle put through that, and

8

again, whether you use the word contamination or

9

artifact that was my concern at that time.

10

Q. Again, Dr. Freedom, if Dr. Taylor

11

gives evidence in these proceedings that he told you

12

about this and you expressed absolutely no interest

13

in the reading, would that surprise you?

14

A. Yes, because that is not my

15

recollection.

16

Q. All right. Can I get on with

17

another matter.

18

After, whether or not it was early,

19

late afternoon or in the evening of Saturday, March

20

21st when the digoxin level in Allana Miller was

21

discovered, what do you know about any steps that

22

were taken at the Hospital for Sick Children to

23

prevent further deaths?

24

A. I had heard that evening that

25

steps were being made to lock up digoxin.



/BB/ak

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Q. Did you know that or is that what you heard?

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A. I wasn't in the Hospital, that's what I was told.

6

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Q. I understand. And who told you that?

8

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A. I just can't recall whether it was a doctor or a nurse or a resident but I was just told that there was a lot of activity in the cardiac ward.

11

12

13

14

Q. Did you know that certainly by the time Justin Cook died that there had been certain rules imposed about securing rooms and IV lines and that sort of thing?

15

16

17

A. Well, again, I can't remember when on Sunday or Monday I was told that but I knew that certainly early that week that there were these matters under concern.

18

19

Q. You can't be of any more assistance?

20

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A. No.

Q. Do I take it that at that time you held the view when you felt in March of 1981 that murder had occurred in the Hospital that the most likely means of administration was the intravenous?



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A. Yes.

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Q. And that depending upon where

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the digoxin be put into the IV mechanism, it can

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be very quick acting or very delayed acting?

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A. Well, I had several discussions

7

with the police and I can't remember whether it was

8

in sort of a private audience or a round table

9

discussion about how digoxin could be administered

10

to achieve the lethal effect.

11

Q. All right. That's a volutrol-

do I use that terminology correctly?

12

A. Correct.

13

Q. And you have used the expression,

14

or do you agree it is sort of like in a Y mechanism?

15

A. Well, there are several

16

different types of administering but the one I was

17

familiar with was a bag connected to a urometer,

18

so to speak, and then a tube going down to the intra-
venous.

19

Q. And is there a number of

20

ports where intravenous - digoxin could be administered?

21

A. Yes.

22

Q. And depending upon where you

23

put it in, would either hasten or delay the apparent

24

effect on the baby receiving it?

25



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A. Correct.

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Q. So, if someone was going to
do it they could do it and there could be a delay
factor?

5

6

A. Correct.

7

THE COMMISSIONER: I'm not too sure

8

I understand how this thing would be. The intra-
venous I take it is a bag up somewhere and it
extends by a tube down into the baby, is that the
idea?

10

11

THE WITNESS: Yes. There was

12

considerable discussion that if a dose of digoxin

13

was going to be administered intravenously, how did

14

the physicians and the pharmacologists think they

15

could be administered?

16

THE COMMISSIONER: Yes.

17

THE WITNESS: Well, one way is

directly through the intravenous by a direct push.

18

THE COMMISSIONER: Yes.

19

THE WITNESS: No. 2 was in the

20

little burette itself which contains 50 cc's of
fluid.

21

THE COMMISSIONER: That's the bag.

22

THE WITNESS: And then above that

23

is a bag with, let's say, 250 cc's, 50 cc's and then

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IV tubing.

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THE COMMISSIONER: I see. There are ports going down along this tube, is that right? Is that where the bolus is?

5

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THE WITNESS: Yes. A bolus I just think means a bolus.

8

9

MR. PERCIVAL: Q. One massive injection?

10

11

A. Yes.

THE COMMISSIONER: No, but a bolus seems to be a ---

12

13

14

THE WITNESS: I would consider a bolus as a relatively small amount or large amount delivered quickly.

15

16

THE COMMISSIONER: Oh, I see.

MR. PERCIVAL: Q. But into some IV fluid that is going into the patient?

17

18

19

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A. Not necessarily in the sense that if you had a port of entry, that is, an intravenous, if you gave it very low down in the tubing, it would go right in.

21

22

Q. Allright. And the reaction would be reasonably quick?

23

24

25

A. I would have thought so.

Q. And if you put it up higher up



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there would be a delay factor?

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A. Correct.

4

Q. 5, 10, 15 minutes?

5

A. Well, I wasn't sure how long

6

a delay but I thought there would be a delay factor.

7

Q. Whoever did it might not have

8

been around when it occurred to have some effect on
the baby?

9

A. Correct.

10

MR. PERCIVAL: Thank you, Doctor.

11

THE COMMISSIONER: Yes, all right,

12

thank you.

13

MR. PERCIVAL: As promised it is

14

two minutes to 1:00.

15

THE COMMISSIONER: Yes, yes, you

16

have done well too, everybody is doing well today.

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How well are we going to do this afternoon, does

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anybody want to predict? Mr. Brown?

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MR. BROWN: My questions will be very

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short.

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THE COMMISSIONER: Miss Forster?

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MS. FORSTER: I expect to be less than

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an hour, Mr. Commissioner.

7

MR. HUNT: I don't think we will be

8

very long, half an hour.

9

THE COMMISSIONER: Well, we might get

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to you Miss Symes, I don't know. For anybody who is

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here by 4 o'clock or 4:30 onwards you will get an

12

opportunity to cross-examine if we reach that, but

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we are obviously continuing, as I said yesterday, on

14

Monday in cross-examination. You don't want to

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proceed now? What time is it, oh, it is 1 o'clock.

16

Then, until 2:30.

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--- Luncheon adjournment.

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AA
DM/PS

1 ---Upon resuming at 2:30.

2 THE COMMISSIONER: Yes, Mr. Brown.

3 MR. BROWN: My apologies for being
4 late. I have no questions of this witness, Mr.
5 Commissioner.

6 THE COMMISSIONER: Ms. Forster.

7 MS. FORSTER: Thank you, Mr. Commissioner.

8 CROSS-EXAMINATION

9 BY MS. FORSTER:

10 Q. Doctor, I would just like to
11 deal with the area of pathology for a moment. How long
12 have you been practicing in that field?

13 A. Well, as I said earlier, I am not
14 a pathologist, I am a pediatric cardiologist, and I
15 have a specific clinical and research interest in
16 cardiac anatomy.

17 Q. And how long have you been in-
18 volved in cardiac anatomy?

19 A. I think my first exposure was in
20 1965 when I took a year off medical school to do
21 basically pathology with an interest in cardiac
22 anatomy, and I have been interested in it for the next
23 18 years.

24 Q. And Doctor, as someone who is
25 involved in the pathology field, would you agree with
me that one of the most important aids a physician has



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in determining the cause of death of a patient is the
autopsy and the results of that autopsy?

4

A. Yes, I would agree with that.

5

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Q. And as I understand from the
evidence we have heard the autopsy may in fact indicate
that a patient's condition was much more serious than
had been anticipated when the patient was alive?

8

9

A. Yes, that is correct.

10

Q. And we heard that that was the
case in baby Taylor, was it not?

11

A. Yes.

12

13

Q. And similarly I take it that
an autopsy could show that in fact a child's condition
was not in fact quite as serious as one had thought
when the child was alive.

15

16

A. I would think that is true as
well.

17

18

Q. In addition, I take it that the
autopsy could reveal a condition the child was suffering
from that no one was aware of when the child was alive?

19

20

A. Yes, that's true.

21

22

Q. Would you agree with me, sir,
that without an autopsy doctors would be somewhat hampered
in arriving at a satisfactory conclusion as to the cause
of death?

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A. Yes, I would definitely agree
with that.

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Q. And Doctor, in the period 1982 and
1981 was it routine to conduct autopsies on patients
who died in the cardiac ward subject to parental consent?

7

A. Yes.

8

9

Q. Was it routine throughout the
hospital or simply on the cardiac ward?

10

11

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A. Well, I believe as in my own
experience is directed to the cardiac patients, but it
is a general rule in any teaching hospital that consent
for autopsies should be asked for on every child that
dies.

14

15

16

Q. What I meant was, was it routine
to conduct autopsies on all children who died in any
other ward other than cardiology?

17

18

A. Yes, it is my understanding it is
done where parents give consent on any ward in the
hospital.

19

20

Q. And is the consent routinely
asked for in other wards as well as cardiology?

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A. Again, I feel most comfortable
directing my attention to cardiology, but I would presume
that the same approach is taken on other floors in the
hospital.



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Q. Can you tell me why in cardiology, with which you are familiar, why is it that doctors routinely ask for consent to do an autopsy?

A. I think unlike other specialties the specialty of pediatric cardiology is really a symphony, so to speak, of structure of function, and a lot of what happens to the patient with congenital heart disease is predicated on the structural abnormality of the heart; the surgery correlations with the angiography and the ultrasound tests. So I am not sure that we would request it any more than anyone else. We think we have a responsibility to the patient and to the family to give them as much information as possible.

Q. Now, Doctor, you indicated this morning, and Dr. Rowe also indicated in his evidence that in arriving at a conclusion as to the most probable cause of death, in addition to looking at the autopsy in the ideal world you would also look at the patient's medical record, tests conducted on the patient and speak to the treating physician, is that correct?

A. That's correct.

Q. And Doctor, I would take it that one area in which you were a particular asset to the hospital is you are involved in both pathology and



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3 cardiology, such that you offered and usually I take
4 it investigate the heart on autopsy, and in addition
5 you are often involved in the actual treatment or
6 care of the particular child while on the ward, is
that correct?

7 A. I would certainly have an on-
8 going interest in cardiac anatomy of the child.
9 As I said early in my examination, I would often see
10 the heart of the individual in relative isolation in
11 the sense I wouldn't be the ward chief, I wouldn't
12 have done the catheter, but I would have attended the
morning conferences.

13 Q. And you would be the person that
14 has the connection with the cardiology ward that also
15 is the one that sees the heart on autopsy, if anyone
16 from the ward sees it, is that correct?

17 A. No, that is not entirely true.
18 I think many times the ward chiefs, the residents
19 and those on the floor who actually have more direct
20 contact also come to the autopsy room and speak to the
prosector and to the pathologist.

21 Q. Are there any particular
22 circumstances when someone other than yourself
23 would be at the autopsy, or is it just if they are
24 particularly interested?
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A. I think if they are particularly interested and again because the university, excuse me, Sick Children's is a teaching hospital and I think there is often more interest to the house officers as well.

Q. Sir, is one of the reasons for your cross-appointment for both cardiology and pathology to assist the cardiologist in particular by giving feedback on the pathological aspects of the hearts you see at autopsy?

A. Well, I think the sort of legacy of how I got that appointment is perhaps more introspective and perhaps more selfish. In a sense, as a clinical cardiologist we all have specific interests in the field of pediatric cardiology.

My interest dating back to the mid-60's has been in the correlation between anatomy and angiography, the heart picture that we take.

Now, in the adult hospitals that I have worked before, that is, Johns Hopkins, I think the pathologist there was somewhat more hesitant to let a "clinician" participate with them in dissection of the heart. I think one of the reasons I joined the staff in 1974 was on the condition that I would have access to cardiac pathology material for my ongoing clinical



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3 correlative research. And again, the secondary
4 benefit, as you suggest, would be to the Division of
5 Cardiology in a more clinical way.

6 Q. I take it also from what you said,
7 Doctor, that the information you glean on autopsy
8 investigation is of assistance to you in the clinical
9 care and treatment of patients?

10 A. Definitely.

11 Q. Doctor, I also take it from some
12 of the things you were saying to Ms. Cronk yesterday
13 that you would caution, in particular a layman, from
14 taking isolated portions of a medical record and
15 drawing conclusions from them.

16 A. Correct.

17 Q. Would you agree that it is
18 important to read the medical record as a whole when
19 following the course of a particular child?

20 A. Yes.

21 Q. And in addition if possible it
22 is preferable also to talk to the staff cardiologist,
23 and in particular the ward chief that is treating the
24 baby at the time?

25 A. Ideally, yes.

Q. Now, Doctor, you have indicated
on a couple of occasions that your understanding of



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digoxin levels has changed considerably since March
1981.

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A. Correct.

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Q. Can you tell me how your understanding has changed?

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A. Well, again, back in March of 1981 when there was a flurry of activity at the hospital, it was my basic understanding that post-mortem level carried the same significance as a pre-mortem level. I have learned through conversations with our entire division of cardiology, the pharmacologists at the hospital and from my own reading subsequent to the events of March of 1981 about the changes in digoxin binding from tissues that happens after death; the type of -- or the observation that digoxin-like substances can react with the immuno assay for digoxin, giving readings for a digoxin-like substance when no digoxin has been prescribed; and for seeing digoxin as it degrades from various other tissues in the body.

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Q. And is there anything, any other way in which your understanding of digoxin levels has changed since March 1981?

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24

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A. Well, again, as one reads the journals one sees certain specific papers. I think it



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2 is through a series of interchanges at the professional
3 level, as a direct contact with physicians, or
4 pharmacologists, plus my reading, plus talking at the
5 hospital.

6 Q. I take it, Doctor, that you are
7 not the appropriate person to ask about the sig-
8 nificance of post mortem digoxin levels and that
9 is better left to a pharmacologist, is that right?

10 A. I couldn't agree more.

11 Q. I take it, sir, that you have had
12 an opportunity to examine many hearts on autopsy.

13 A. Correct.

14 Q. And some of the hearts you would
15 have examined were from babies who died after unsuc-
16 cessful resuscitation efforts?

17 A. Yes.

18 Q. And is there any particular kind of
19 damage, or damage you see in those hearts as a result
20 of the resuscitation efforts?

21 A. Yes. Not infrequently one will
22 see bruising of the surface of the heart. I have seen
23 perforation of the heart. I have seen where children
24 had been given injections through their chest into the
25 heart during resuscitative efforts where the arteries
supplying the heart had been damaged. Contusions from



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the chest wall, all sorts of things related to so-called trauma at the time of resuscitation.

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Q. And are these things that you always see or just that you may see?

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A. That you may see.

7

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Q. And similarly, do you see any particular kind of damage to the heart as a result of electric shock treatment that is given to a baby during resuscitation or otherwise?

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A. I can't think directly of, you know, closed chest electrical shock. I certainly have now read about the effect of electrical shock on heart muscle, where it leads to, or leads to cardiac enzymes. I guess the analogy would be if an individual has a heart attack where their heart muscle dies it releases cardiac enzymes into the bloodstream. There is now a body of literature discussing that aspect from cardio version, from electrical shock.

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Q. Can you tell this from looking at the heart on autopsy?

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A. No, I don't believe I can. I would wonder whether a cardiac microscopist that is, one who is interested specifically in looking at the heart under a microscope and doing very sophisticated types of electronic microscopy



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3 with special stains and perhaps they would have that
4 advantage. I can't think of seeing the effect directly
5 upon the heart wall itself.

6 Q. Doctor, you have already
7 indicated today and yesterday that during the period
8 under review you had the feeling that there were sicker
9 and younger babies in the ward. You explained to
10 Mr. Ortved I believe that you thought **one of the reasons**
11 for that would be the problem they were having in the
12 hospitals in Winnipeg. Is there any other explanation
13 you have for why there would be sicker and younger
14 babies during that period?

15 A. Well again we had increased the
16 size, we had another 4 infant beds. I believe it is
17 the policy of the --

18 THE COMMISSIONER: That would produce
19 more babies but it wouldn't necessarily bring sicker
20 and younger babies, and I think that is the question
21 that was put to you.

22 THE WITNESS: I agree with your com-
23 ments, Mr. Commissioner. But because the beds that were
24 increased with infant beds, I would have anticipated
25 seeing more infants, and by definition in the
hospital they must be sick. The whole purpose of the
new ward was to increase the infant beds.



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THE COMMISSIONER: Yes, I understand that. I hope someone some day will give us some evidence rather than just an impression of whether there were more and sicker. That there were more, I suppose that can be established by statistics. I don't know how we establish whether they were sicker or not. Your impression was that they were sicker, is that right?

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THE WITNESS: Yes.

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Q. And do you have any explanation as to why you were seeing sicker babies as opposed to just more babies?

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A. Again, I think as we discussed this morning and perhaps yesterday, I think we cardiologists have been, have perceived the so-called concept of clustering and whether this was just a clustering phenomenon or sicker babies. The type of infants, the type of patients that were transferred from Winnipeg were often younger babies, the children needed relatively urgent surgery and that was specifically very true of the St. Boniface unit.

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Q. Dealing with the situation in Winnipeg for a moment. When was it that the babies were transferred from Winnipeg?



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A. I don't know the exact date, but
it is my recollection it was 1979-1980.

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Q. And do you recall how long that
situation continued?

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A. It has continued throughout until
about, I would say, six months to a year ago.

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Q. I didn't catch this morning as
to what you said as to why that was, why the babies
were coming from Winnipeg.

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A. Well, I believe they were having
problems with surgery, at least the results of the
surgery as perceived by the head of Pediatric
Cardiology at the Children's Centre, and the head of
Pediatric Cardiology at the Children's Centre in
Winnipeg. Again, he was pretty much alone as
a cardiologist and he made the decision to send
the sicker children to Sick Children's.

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Q. Do you recall the name of the
doctor?

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A. Yes. It is Dr. Gordon Cumming,
C-u-m-m-i-n-g.

Q. And when you say problems with
surgery, was the concern that they were having very
high morbidity rates in surgery, or the resources;
what do you mean by that?



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A. Well, I am not privy to all the things that went through Dr. Cumming's mind. All I know is that he felt the children would have a better surgical result at the Hospital for Sick Children.

THE COMMISSIONER: It is a relatively easy matter how many of these children did come from Winnipeg, there was one I know.

THE WITNESS: That would be I guess enumerated, that is the 36 we are looking at.

THE COMMISSIONER: Yes.

THE WITNESS: What we don't have is the denominator, at least, I'm sorry, I don't have.

THE COMMISSIONER: I don't know, you go ahead, Ms. Forster.

MS. FORSTER: I have finished with that, Mr. Commissioner.

THE COMMISSIONER: This may help us out but so far I am not convinced that the Winnipeg exodus was important, but it may become. It may well be. I remember certainly one child and I remember Dr. Cumming, but I can't identify the child now.

THE WITNESS: I believe it was Real Gosselin.

THE COMMISSIONER: Was it?

THE WITNESS: Yes.



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3 THE COMMISSIONER: Were there any others
4 of our 36 that came from Winnipeg? That as I say we
5 have a numerator and denominator problems, but were
6 there any others that came from Winnipeg?

7 THE WITNESS: I can't -- I don't
8 think there were others of the 36 which I consider
9 the numerator, but what we have not explored
10 is there are a lot of patients that went through
11 the Hospital for Sick Children, cardiology, during
12 the same time.

13 THE COMMISSIONER: But the fact that
14 those children survived would seem to advance the
15 argument, because the others all survived so that
16 would mean you were getting healthier babies
17 from Winnipeg.

18 THE WITNESS: Perhaps our expertise
19 was getting better.

20 MR. ORTVED: Or they died other than
21 on the ward.

22 THE WITNESS: That is right.

23 THE COMMISSIONER: It is possible.

24 Q. Doctor, you also mentioned yes-
25 terday I believe that by the summer of 1980 the
Hospital for Sick Children had its transport helicopter
in place.



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A. I said I thought that was my impression, that I wasn't certain as to when the exact time of that was.

Q. Is it your understanding that the presence of that helicopter had an effect on the kinds of babies you were receiving on the cardiac ward?

A. It was my understanding that because these children were being transferred here that it was filling up the ICU, at least there was more space in the ICU being used by children, let us say, with motor vehicle accidents and that type, and that perhaps that would reflect what children were dying on the floor, that is that they were not being able to be transferred to the intensive care unit.

Q. It is my understanding, Doctor, that in ICU there was a specific number of deaths reserved for cardiac patients, am I incorrect?

A. I am not saying you are incorrect, I was saying that ideally it is true, we have an on-going service commitment, but certainly there were times of clusters of drownings during the summer, accidents during the skating season, head injuries where the beds are disproportionately utilized by one service over another.



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Q. Doctor, I would like to take you to the case of baby Shrum. I wonder, Mr. Registrar, if you could give the doctor Exhibit 53.

Doctor, I have just a couple of questions for you with respect to this baby.

Firstly, as I recall your evidence you said that you couldn't remember whether you were at the gross autopsy of this child but you do recall seeing the heart and lungs.

A. Correct.

Q. And I direct your attention to Page 20 of the record which is the final autopsy report.

A. Page 20?

Q. Page 20 and in particular Page 21 which is the second page of the report.

A. Yes.

Q. Have you reviewed this report before, Doctor?

A. I certainly had reviewed it before, you know, these proceedings, and I presume I saw it after this child died.

I can't recall specifically.

Q. And as of today's date are you satisfied that it adequately explains the cause of



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death of this child?

A. Yes, I am.

Q. And secondly, dealing with baby Velasquez. I wonder, Mr. Registrar, if the witness could be given Exhibit 54.

Doctor, I wonder if you could turn to the first page five which is the second page of the Wilkenson memo.

A. Yes.

Q. Ms. Cronk asked you about this memo yesterday or the day before and I believe you gave evidence involving 28, Page 50 to 54 that in your opinion the only symptom the child exhibited prior to being given Naloxone that was consistent with digitalis intoxication was bradycardia, is that correct?



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A. Yes. I believe my response was
could bradycardia be consistent with digoxin and the
answer was yes.

THE COMMISSIONER: That is not quite
the same answer as the question. Do you want to try
the question again, Doctor?

THE WITNESS: I would have to see my
exact testimony, Mr. Commissioner, to see exactly how
I responded to it, I am sorry.

THE COMMISSIONER: All right.

MS. FORSTER: It is page 5254.

THE COMMISSIONER: What volume?

MS. FORSTER: Volume 28.

Q. Miss Cronk had asked you:

"Q. Are any of the symptoms which
appear to have been displayed by the
child prior to the administration of the
first dose of naloxone suggestive in
your view of potential digoxin effect?

"A. One could be concerned that
bradycardia could be a manifestation
of digoxin effect or toxicity."

A. Yes.

Q. And I take it from your answer,
Doctor, you are not saying it definitely shows



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digoxin intoxication; you are simply stating that is a symptom or a finding that is also found in cases of digoxin intoxication?

A. Yes, I would agree with that.

Q. Up until the time the child is given naloxone is there any other evidence you are aware of to suggest this child was suffering from digoxin intoxication?

A. No, there was not.

Q. Dr. Rowe testified, Doctor, in Volume 12 at page 1951 that in his opinion had this child been suffering from digoxin intoxication one would not expect him to perk up the way he did when he was given naloxone?

Do you agree with that?

A. Yes, I do.

Q. And, Doctor, is it still your evidence today that the most probable cause of death of this baby is an idiosyncratic reaction to the naloxone?

A. Yes, it is.

THE COMMISSIONER: Have we done any investigation on the frequency of this?

THE WITNESS: Well, again it is my understanding that this is an extremely uncommon situation.



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THE COMMISSIONER: Would it be unique?

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THE WITNESS: No, it is certainly not

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unique because it has already been produced in

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evidence that at least two adult patients had had

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the experience.

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THE COMMISSIONER: Yes.

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MS. FORSTER: Q. Doctor, I next want

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to take you to the Estrella baby. I don't believe

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you will need the record for this, but if you do,

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please feel free to ask for it.

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You mentioned when you were advised

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of the postmortem levels in Baby Estrella --

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A. Yes.

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Q. -- your first reaction was there

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must be some kind of mistake, either a decimal error

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or the possibility of contamination, and you gave us

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yesterday one example of how a sample could be

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contaminated.

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I am wondering are, on autopsy, there

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any other ways in which a sample could be contaminated?

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A. Yes. I think that if - again

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it depends upon the time of death vis-a-vis the time

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the sample was taken.

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If stomach, if the baby had taken
digoxin by mouth and the stomach contents were mixed



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with the blood that was taken, with the degeneration of tissues after death where I now understand that digoxin is cleaved so to speak from its binding with the tissues, with fluids that interface, it could lead to an artifact or a contaminated sample.

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Q. How does that happen?

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A. Well, again it is my understanding, and as you suggested I certainly am not an expert.

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Q. Oh, I am sorry. I am not talking about the reaction of digoxin. How does it happen that the stomach contents and the fluid become inter-mixed?

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A. Often when an autopsy is done heart and lungs are dissected free from the airway and not infrequently you cut across the esophagus, the stomach tube, and if one is predisposed on thought you had better get a blood sample, it is conceivable you would get such mixing of tissues.

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Q. If contamination were to occur on autopsy --

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A. Yes.

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Q. -- would the contamination be readily apparent to the person conducting the autopsy or could it happen inadvertently and unbeknownst to the person conducting the autopsy?



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A. I think so much has happened in the past two and a half years I think it would depend on when the sample was taken in time and what one's understanding was of digoxin metabolism after death at that time.

I think certainly if a sample was taken in 1981 before one realized that contamination of this sort could happen and have an effect, one wouldn't even consider it.

I think as of today we would all be more careful about the timing of the sample, how a sample was taken, is a sample taken through the heart muscle.

Q. All right.

A. And we know that if a needle is placed through the heart muscle and we know that the heart muscle is extremely rich in digoxin, a contaminant could happen there. So again all of these things have to be considered and certainly are today.

Q. What I am asking, though, Doctor, if today you were conducting an autopsy and in the course of the autopsy you were taking a sample for testing digoxin, and the sample became contaminated, would you know it was contaminated or could it happen unbeknownst to you?



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A. I think it could happen both ways. I think that certainly if you took fluid from the abdominal cavity or gutter where tissues have interfaced, one would know today it was probably contaminated.

I think it is conceivable that one could stick a needle through a child's heart to take a postmortem level, not perceiving that small amounts of heart muscle were in the needle, you inject the blood into a tube and I think that could also occur.

Q. So no one could ever - one could not know with 100% certainty no matter when the testing was done whether or not it was done on a contaminated sample.

A. Well, yes, I would agree with that. I have a little trouble with the word "contaminated", but certainly on the sample that is artificially increased because of exposure to the substance that I mentioned, heart muscle, et cetera.

Q. And lastly, Doctor, was it your understanding that in June of 1980 or around that period of time the house physicians at the Hospital were on a work to rule campaign?

A. Yes, they were.

Q. Do you recall when that started?



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A. No. I guess the only thing
I recall I was livid about it.

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Q. And did the work to rule
campaign affect only the residents or the fellows -
I take it from your reaction staff cardiologists
were not involved in it? Was it confined to fellows
or residents?

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A. It was certainly confined to
the majority of the residents and to at least some
of the fellows.

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Q. And that included some of the
fellows and some of the residents on Wards 4A/4B?

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A. Yes. Well, let me retract
that a little bit.

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I know that at least one or two of
the cardiac fellows supported the work to rule. It
is my recollection that at least one of them was on
the floor at the time, and that a great amount of
discharge letters, et cetera, were backed up because
of that work to rule.

Q. Do you recall how many of
the residents at the time were on the work to rule?

A. No, I don't.

Q. Would it be the majority of
them?



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A. I just can't say, but I think we could get that information. I think the work to rule was of relatively short duration; a few days.

Q. And what effect did you see it having on the operations of that ward in terms of the manhours put in by the doctors and the care of the children?

A. I think my recollection, again it is just that, I remember being upset. I felt the residents were not working hard enough as it is and getting too much money and I couldn't understand why they would take off all this time. So I think that there was some change.

I was a little bit concerned, as I suggested, that some of the discharge letters weren't being done. I don't think it made a direct effect on the patients because other fellows filled in.

Q. When we talk of work to rule, what kind of hours were these residents working when they were working to rule?

A. It was my understanding it was 9:00 to 5:00 and on call every third to fourth night.

THE COMMISSIONER: Was that after the work to rule or was this before?

THE WITNESS: I think it was before.



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THE COMMISSIONER: Then after the
work to rule what did they do?

THE WITNESS: I believe it was the
same sort of 8:00 or 9:00 to 5:00, with less on call
and that type of thing.

MS. FORSTER: Q. Do you recall how
less on call?

A. No. It always caused my ulcer
to act up.

Q. Okay.

THE COMMISSIONER: Anyway, before we
get worked up about this work to rule, did it end
before June 30th?

THE WITNESS: I can't recall
precisely, Mr. Commissioner.

THE COMMISSIONER: Do you know,
Miss Forster?

MS. FORSTER: No, I don't, sir.

THE COMMISSIONER: Well, if it did
end before June 30th it is merely a bleak episode
in history, but if it ended after June 30th it may
be more serious.

MS. FORSTER: Q. It had been my
understanding that it continued after June 30th, but
I don't have the dates.



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A. I was going to say that it is my recollection it ended before the changeover of new residents but I could be mistaken.

MS. FORSTER: So could I.

THE COMMISSIONER: Changeover is ended before April? Is that it?

THE WITNESS: No, I'm sorry, Mr. Commissioner. The academic year for house officers ends June 30th.

THE COMMISSIONER: I see.

THE WITNESS: And starts July 1st. But I may be mistaken.

MS. FORSTER: Thank you, Doctor, those are all my questions.

THE COMMISSIONER: Thank you.

Mr. Hunt?

CROSS-EXAMINATION BY MR. HUNT:

Q. Dr. Freedom, I wanted to deal first with Baby Velasquez.

A. Yes.

Q. You were asked by Miss Cronk whether or not you knew upon what basis the death of Baby Velasquez was not accepted by the coroner for investigation.

You indicated you couldn't recall your



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exact discussions with Dr. Gartha.

A. That is correct.

Q. You were also asked whether, when you had discussions with Dr. Gartha, you had any discussion with respect to the effect of naloxone on the cardiovascular system?

A. Yes.

Q. And while you thought you had mentioned it to him you couldn't remember precisely at what times you addressed the various issues?

A. That is true.

Q. Just to see if we can clear that up, I would ask you to look at your memorandum. It is in Exhibit 54, the Hospital record, and it is at page --

A. Yes, I have it.

Q. -- page 6.

Now this memo that you prepared for Dr. Rowe was prepared on the 26th of August?

A. Correct.

Q. 1980. And that was two days after Baby Velasquez died?

A. Correct.

Q. And am I correct that he died



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in the early hours of Sunday morning the 24th?

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A. Yes.

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Q. You first contacted the
coroner's office some time on the Sunday?

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A. Yes.

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Q. And the time that I have it
is 2:42 p.m. Would that accord with your recollection?

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A. Well, it says I was notified
about 3:30, and I guess that could have been an error
by an hour because it was in the middle of the night.
Maybe I did call him earlier.

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Q. No, it was 2:42 p.m. is the
time I am suggesting which would be Sunday afternoon.

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A. It is my recollection that I
called him earlier.

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Q. All right.

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A. In the morning.

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Q. All right. But in any event
you were notified Sunday morning at approximately 3:30.

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I take it that you at some point on Sunday morning
went into the Hospital?

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A. Right.

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Q. And you examined the chart?

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A. Correct.

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Q. And as a result of your

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3 concern over the temporal connection, if any, between
4 the administration of naloxone and the onset of
5 terminal events, you then discussed the matter with
6 at least two colleagues at the Hospital?

7 A. It was my recollection that
8 that was done, that I received this call in the wee
9 hours of the morning from Dr. Wilkinson, that we
10 discussed over the phone with Dr. Wilkinson the
11 sequence of events, the medications that Antonio was
12 taking at the time, and again unfortunately my memo
13 is not specific as to what times I called these
14 people, whether it was that time or, you know, at
15 a more reasonable hour.

16 Q. All right. Well, in any event
17 it was prior to speaking with Dr. Gartha some time
18 on the Sunday that you spoke to Drs. Conn and MacLeod?

19 A. Correct.

20 Again I can't remember whether I spoke
21 to them before I spoke to Gartha - I spoke to Gartha
22 a couple of times on Sunday - or whether I had spoken
23 to Gartha and then spoken to the physicians and then
24 got back to Dr. Gartha.

25 Q. All right.

A. So I just don't have that
recollection.



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Q. In any event you spoke to him
some time on Sunday after you spoke to Drs. Conn and
MacLeod?

A. Right.

Q. Your memo would seem to
indicate that you had in fact obtained opinions from
Drs. MacLeod and Conn prior to contacting Dr. Gartha,
whether it was for the first or second time.

A. Correct.

Q. And I am looking at the
seventh paragraph, just the second paragraph from
the bottom, which indicates:

"With these facts in hand I contacted
the coroner on call for Sunday,
Dr. I.V. Gartha, and discussed the
case with him."

A. Yes.

Q. Those facts were the facts
with respect to the administration of naloxone?

A. Yes.

Q. And the opinions of Drs. Conn
and MacLeod?

A. Right.

Q. Now you indicated that during
some of the questions from Miss Cronk that you weren't



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3 a clinical pharmacologist, and really it was a
4 person of that expertise that was best able to answer
5 questions with respect to the effects of naloxone.

6 A. Correct.

7 Q. And I take it that is why you
8 sought out Dr. MacLeod?

9 A. Yes. It had been my impression
10 in using naloxone, narcan, that one would continue
11 to give this medication until one saw the desired
12 effect. That was number one.

13 Number two is I was certainly impressed
14 with the temporal relationship between the second
15 dose and the final events of little Velasquez. So I
16 had been concerned did those individuals with more
17 experience have a different perception of what narcan
18 could do.

19 Q. I understand that, and it was
20 in order to get the opinion of someone who had that
21 experience with respect to the effects that you spoke
22 to Dr. MacLeod specifically, was it?

23 A. Yes.

24 Q. He was head of clinical
25 pharmacology?

A. Yes. I can't remember at the
time if I knew he was the head of clinical



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2 pharmacologists or a pharmacologist. I tried actually
3 I think in fact to get Dr. Gill Hill who was the
4 head of chemistry, misunderstanding the names. But
5 I did speak to MacLeod and Conn.

6 Q. All right. So in any event
7 you had spoken to Dr. MacLeod and you then contacted
8 Dr. Gartha whether it was for the first time or the
9 second time?

10 A. Excuse me, I think I had
11 spoken to both Dr. Conn and MacLeod before I spoke
12 to Dr. Gartha.

13 Q. Before you spoke to him at all?

14 A. I had spoken to both of those
15 physicians and then I spoke to Dr. Gartha. As I say,
16 I can't remember the time framework whether I had
17 spoken to Dr. Gartha the first time and then spoke
18 to the two doctors.

19 Q. All right.

20 A. Eventually I had spoken to
21 both of the HSC doctors and then contacted Dr. Gartha.

22 Q. All right. So finally you are
23 on the phone with Dr. Gartha?

24 A. Right.

25 Q. And you have received informa-
tion from Drs. Conn and MacLeod, and specifically



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2 from Dr. MacLeod with respect to the effects of
3 naloxone.

4 A. Well again, you know, I just
5 have to go by what my memo says. I can't remember
6 the exact conversations, but I was certainly under
7 the impression they felt it was most unlikely that
8 narcan would do any of this.

9 Q. All right. And they are the
10 experts with respect to the effects of narcan?

11 A. Correct.

12 Q. So you get on the phone with
13 Dr. Gartha and fairly you express your concern about
14 the temporal relationship between the administration
15 of the drug and the demise of the patient?

16 A. Yes.

17 Q. And you then in addition tell
18 him that you have spoken to Drs. Conn and MacLeod
19 about the concerns you had about that?

20 A. Right.

21 Q. And you tell him as well that
22 they are of the opinion that it is unlikely that that
23 administration had any effect on the cardiovascular
24 system?

25 A. Right.

Q. And they being the experts in



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3 that particular area?

4 A. Right.

5 Q. And then as you say in the
6 last sentence in that paragraph after that informa-
7 tion had been passed on to him, including the
8 opinions of Drs. MacLeod and Conn, he then informed
9 you that the case would not be one --

10 A. That was my understanding.

11 Q. -- that would come under the
12 coroner's jurisdiction?

13 A. That was my understanding.

14 He understood that the child had heart surgery, had
15 had small pulmonary arteries, and that I was concerned,
16 was perhaps a mild degree of heart failure.

17 Q. So before he advised you that
18 the case would not come under the coroner's juris-
19 diction you had made him aware of the opinions of
20 Drs. Conn and MacLeod?

21 A. Yes.

22 Q. With respect to the lack of
23 their belief that the drug had any effect?

24 A. Yes.

25 Q. Now then am I correct that a
post mortem examination was in fact carried out with
the consent of Mrs. Velasquez later on on that Sunday?



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A. Yes. That is my understanding.

3

I can't remember who gave the consent for it, but I
remember a post mortem was obtained.

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Q. It would appear from the

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report of the postmortem examination on page 2 that
that was done at approximately 1600 hours so that
would be 4 o'clock in the afternoon?

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A. Yes.

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Q. And then your memo goes on

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to indicate in the last paragraph there was nothing
found at the time of the gross examination that
could explain the death of Antonio Velasquez?

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A. Yes.

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Q. And this matter was further

15

discussed the following morning at the conference
at the division of cardiology?

16

A. Right. And Dr. Rowe felt

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again that I should call Dr. Gartha, telling him of
Dr. Rowe's concern that in view of the anticipation
that Antonio should have done reasonably well, that
we should again have it under the coroner's juris-
diction, and I did that.

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Q. And I take it at this time as well there was now new information that you didn't have on the Sunday and that was that the post mortem examination had revealed nothing that could explain his death, at least from gross examination?

A. Well, again, I felt that, and I mentioned I think it was yesterday or the day before, I felt that clinical service, and again I was the ward chief, had underestimated the severity of the congestion because there was fluid in his abdomen and chest cavities. But again I think I would have been surprised if that would have led to this baby's death.

Q. So, eventually you were back in touch with Dr. Gartha and there is no question the case was accepted by him for investigation?

A. Correct. I can't remember the exact conversation but I said there was a lot of concern from Dr. Rowe, the Head of Cardiology, that this patient should come under a coroner's jurisdiction.

Q. Right. Now, I want to clear up one other matter, sir, and this arose during the re-examination by Mr. Scott of Dr. Rowe and it involved again Antonio Velasquez. I just want to read you a brief portion of that and then I will ask you



CC.2

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a question. It begins, Mr. Commissioner, in Volume 26
at page 4856, line 20.

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THE COMMISSIONER: I don't have it,
but is it going to be lengthy?

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MR. HUNT: No, it's not very lengthy
at all:

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"Q. Let's take another example where
one of the three where you called the
coroner, Velasquez, did the coroner
initially agree to take up that case?

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"A. No.

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"Q. Why not?

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"A. I'm not sure why not.

14

"Q. But, in any event, he didn't take
it up?

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"A. No.

16

"Q. Did something later appear about
it in the newspapers?

17

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"A. Yes.

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"Q. Then, what happened with respect
to the coroner? I'm sorry, I should
interrupt you. When the coroner
decided not to take up the case, did
the Hospital investigate the death as
best it could?

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CC.3

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"A. Yes, we did. We looked into
that ourselves, yes.

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"Q. And I think we have already
heard your explanation at that time
for that death - an idiosyncratic
drug reaction?

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"A. Yes.

8

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"Q. Now, did the coroner, after that,
take up the case?

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"A. Yes, he did."

11

12

Now, firstly, would you agree with me
that it would appear from that that the impression is
left that it had something to do with a report in
the newspaper that caused Dr. Gartha to take up this
case for investigation?

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A. No, I don't think that's correct
at all.

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Q. No, that's my next question. Do
you agree with me from what I just read to you that
it would sound as if there was something in the
newspaper that caused him to take action?

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A. Yes.

Q. All right. And is there any
basis for that at all?

A. No.



CC.4

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Q. All right. So, you are the person who was involved with it, it was as a result of you getting back to him following your conference on the Monday morning with respect to Antonio Velasquez with whatever information you had at that time that caused him to take up the matter as a coroner's investigation?

A. Correct. Indeed, the only time I have ever seen a commentary in the newspaper was during the conduction of these hearings where I saw this comment in, I think it was The Toronto Star.

Q. All right. And that was after Dr. Rowe's initial examination in chief by Mr. Lamke?

A. Or during it, yes.

Q. Or during it where there was a suggestion that the coroner was not interested in the Velasquez case?

A. Yes.

THE COMMISSIONER: What was it, Doctor, that persuaded the coroner to take it up the second time?

THE WITNESS: Again, I think it was when I called him on Monday and I stated that our entire division was concerned by the progress or, excuse me, the death of this child, that it had a



CC.5

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very strong temporal relationship to narcan and I
said, finally ---

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THE COMMISSIONER: You really just
told him a better story on the second occasion, do
you think that was it?

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THE WITNESS: Well, I don't think
Dr. Rowe carries more physical weight but he certainly
carries a lot of weight.

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THE COMMISSIONER: Yes.

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MR. HUNT: Q. Now, you were asked by
my friend Mr. Ortved this morning whether or not on
March the 21st, which was Saturday, March the 21st,
you would have thought that the death of Allana Miller
was a reportable case to the coroner and you indicated
that you didn't think it was at that point in time.

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Now, you have explained that you were
in to the Hospital that morning to do two catheter-
izations, is that correct?

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A. Correct.

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Q. And it was during the course of
those, or some time during the course of the morning
you viewed the heart of Allana Miller?

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A. Correct. I think I saw the heart,
lungs, liver and spleen.

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Q. All right. Now, did you for any



CC.6

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purpose that morning review the chart, the medical records with respect to Allana Miller?

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A. No, I don't believe so. I was very rushed that morning with the two catheter studies, so, I remember going to the autopsy room just wanting to see what had transpired to that junction.

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Q. All right. Now, as of that Saturday morning there was knowledge within the division certainly of the Estrella and the Pacsai readings, the digoxin levels?

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A. Yes, within the division.

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Q. And you were aware that a meeting had been set for that afternoon with the coroner to discuss those levels?

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A. Again, I can't remember specifically if Estrella was mentioned. I do remember the comments late on Friday about Pacsai's level and again during my interaction of the Hospital on Saturday morning I heard there was going to be a meeting with the coroner.

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Q. Right. And there was no question that there was considerable concerns on the part of, if not yourself, some of your colleagues, on that Saturday with respect to this situation of Estrella and Pacsai?

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A. Certainly in retrospect as I have gleaned the facts, yes, that's true.

Q. Were you aware that there was concern as well of a very serious nature that morning with respect to the fact that Allana Miller had died?

A. Well, I knew there was concern. Again, I had been called that morning that she had died.

Q. And that there was concern with respect to the question of whether or not digoxin had played any role in her death?

A. Well, again, it was my understanding, at least as I left the Hospital on Friday evening that digoxin had been held, that the level was very low, you know, I think I said .6 or .9. So, I would not have had that concern that night that digoxin would have played a role.

Q. You weren't aware as of that morning I take it that digoxin had been administered to Allana Miller at 9 o'clock in the evening on Friday night?

A. No. I think the first time I learned of that was when Mr. Austin Cooper pointed that out to me during the hearing.

Q. I take it he indicated to you



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that at 9 o'clock Nurse Nelles administered .032
nanograms of digoxin to Baby Miller?

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A. Yes, that's correct.

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Q. And were you aware that at 2:30
in the morning on the 21st, shortly before the
terminal events took hold, that a hold digoxin order
was placed with respect to Allana Miller?

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A. No, I didn't appreciate that.
Again, until Mr. Cooper pointed out to me and he took
me through the Hospital chart at the hearing, so, as
I said when I left on Friday I had had a word with
one of the residents and I suggested although her
level was low let's hold the dig. because she seemed
a little better.

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Q. All right. So, in giving your
answer to Mr. Ortved with respect to the reportable
nature of this case, as of that morning you were unaware
of those two facts?

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A. Correct.

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Q. And as a matter of fact I think
when you left the Hospital on Friday evening you had
indicated that it was your suggestion that the
digoxin be held?

A. Correct.

Q. So, as far as you were aware on
the Saturday morning that was the case?



CC.9

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A. Correct.

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Q. All right. And were you aware

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that as of the Saturday morning at least Dr. Rowe
and perhaps as well Dr. Fowler were very concerned
with respect to the situation of Allana Miller's
death and digoxin, the effect it might have had?

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A. No, I can't say I was aware.

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MR. ORTVED: What's the basis for that?

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MR. ROLAND: That's not been the

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evidence of Dr. Rowe at this point.

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MR. HUNT: Well, if I could just direct

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my friends to Volume 23, page 4249, line 14, and

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perhaps it might be simpler if I just read the
question and answer.

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THE COMMISSIONER: Yes, all right.

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MR. HUNT: "Q. I think you

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indicated that going into that meeting

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Saturday afternoon you were at the

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least very concerned about the Miller

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situation, at that time you didn't

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know what the levels were?

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"A. I think that is true."

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Page 4251 at line 6:

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"Q. Certainly I suppose next to Pacsai

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and Estrella it had to be a matter that

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"was near the top of the concerns that
you had going into that meeting?

"A. Oh, yes, absolutely."

THE COMMISSIONER: Yes, and now the
question is?

MR. HUNT: Q. The question was, were
you aware as of that morning that the Miller situation
was of serious concern to at least Dr. Rowe and
perhaps Dr. Fowler as well?

A. I don't believe so.

Q. All right.

MR. ORTVED: Well, I think that
portion of Mr. Hunt's cross-examination of Dr. Rowe
was substantially altered on re-examination. I think
the whole of it should be put to Dr. Freedom.

THE COMMISSIONER: Well, no doubt it
should if that is so, but any rate the answer has been
I was not aware of it, so, it really isn't going to
change the answer at all.

MR. ORTVED: No, but I just want to
make sure that we are all clear on the purport of
Dr. Rowe's evidence, which was to the effect that
when he gave those answers to Mr. Hunt he may have
been under a misapprehension.

MR. HUNT: No, if my friends want to



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point me out the precise passage that they say alters that. There is no question that Dr. Rowe when he was being re-examined changed his opinion with respect to the reportability of the case but this doesn't deal with it, this deals with whether or not as a matter of fact he was concerned about the death of Allana Miller and about the levels going into that meeting.

THE COMMISSIONER: Yes. I think as I said to Mr. Ortved, Mr. Hunt, I don't think we need to go, in light of the answer that the witness has given, and I don't think we need to go into it.

MR. HUNT: Perhaps not.

THE COMMISSIONER: By the time we get to arguing this case that point will be long since forgotten and will have to be raised again.

MR. HUNT: All right.

Q. Well, in any event, sir, in light of the information which you perhaps were not aware of on the Saturday morning with respect to digoxin, in light of the fact that you were not aware of the concern that some of your colleagues may have had and that you are now aware of that information, would you agree with me that even as of that Saturday morning the death of Allana Miller was a case that certainly required the most serious investigation?



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A. I have some trouble with that in the sense that I perceived Allana, although I thought she looked a little better Friday evening, she was a sick baby, she was having a rhythm disturbance. I even told the family I didn't think it was safe to send her home to wait for surgery, that I wanted to keep her in. So, I felt she was very sick. Now, if you are asking me in view of the Pacsai levels did I think it should be reported it is hard for me to judge.

Q. No, I am just asking you whether in light of the information you had at that time, what you now know about the digoxin, the administration of it on the Friday night, the holding of it ---

THE COMMISSIONER: What he then knew?

MR. HUNT: What he then knew and what he now knows about that.

THE COMMISSIONER: Wait, wait, wait. In light of what he now knows I don't think there is much question that it should be reported but what he then knew - isn't that what you're asking?

MR. HUNT: Well, I took the question that my friend asked this morning as going to his opinion as of now, whether or not this was a reportable matter, not so much as to whether it was or was not



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on the morning of the 21st and that's what I'm
directing these questions to.

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THE COMMISSIONER: Well, I want to
know now whether it should have been reported in the
morning, is that it?

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MR. HUNT: Q. In light of all of that
information that you now know, I say, would you agree
with me that as of that morning it was a case that
required a serious investigation?

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A. I don't think so.

11

Q. I beg your pardon?

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A. You've lost me a little bit,
maybe it is late in the afternoon.

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Q. All right.

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A. Knowing that the baby had
received a digoxin dose at 9 o'clock that evening
would that have influenced me?

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Q. No, the question, sir, is,
knowing now ---

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THE COMMISSIONER: If you had known
then everything that you know now.

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THE WITNESS: I would have reported it.

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THE COMMISSIONER: You would have
reported it.

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MR. HUNT: Fine.

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Q. And you would have regarded it certainly as a case that required a very serious investigation?

A. Yes.

THE COMMISSIONER: It seems to have required a Royal Commission.

MR. HUNT: Thank you very much, those are all my questions.

THE COMMISSIONER: Is that it?

MR. HUNT: Those are all my questions, yes.

THE COMMISSIONER: That's all your questions. What do you want to do, do you want to start now or would you like to take a break now, Miss Symes?

MS. SYMES: If you're going to take a break I would ask that we do it now.

THE COMMISSIONER: Yes. We do the break now or we do the questioning now?

MS. SYMES: Could we take a break now?

THE COMMISSIONER: Oh, we'll take the break now, all right. How long do you think you'll be? I want ;to finish, that is if possible ---

MS. SYMES: Could we take a relatively short break and I will certainly make every attempt



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to finish by 4:30.

THE COMMISSIONER: Yes. I am supposed to be - I don't seem to be able to get rid of my other job, I am supposed to do something else at 4:30. Do you have a reasonable hope of finishing by, say, 4:20?

MS. SYMES: I will try.

THE COMMISSIONER: It won't matter of course if you go on because there are other examinations going on on Monday, so, if you don't finish you don't finish.

We will take 15 minutes then.

--- Short recess.

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---Upon resuming.

THE COMMISSIONER: Yes, Ms. Symes?

CROSS-EXAMINATION

BY MS. SYMES:

Q. Dr. Freedom, as you know, I represent the RNAO and 36 of the nurses that worked on the cardiac ward during this particular period. So my questions to you will be from their perspective.

First of all, I understand that you were the doctor on the cardiology ward that was consulted frequently by nurses.

A. About patients?

Q. About patients, about nursing, about almost everything?

A. Well, you know, I spend a lot of time on the floor whether I am on service or not, so I would see the girls quite frequently.

Q. And I understand in fact as you say one of the reasons it is your practice to get there very early in the morning?

A. Right.

Q. And so you tended to see the night nurses before they went off shift.

A. No, I wouldn't say that at all. I tend to get there early so I can get my writing done.



Often when I am not on service I wouldn't go to the floor at all, I would just go right to my office for three hours of uninterrupted work.

Q. Did you also stay late?

A. Yes. Well, 7:30 - 8 in the evening.

Q. At night?

A. At night.

Q. So you regularly put in 12, 14, 16 hours a day?

A. Yes.

THE COMMISSIONER: Have you paid Ms. Symes for this?

Q. No, the next thing we are going to tell them is we are going to try to unionize the hospital for all staff to cut down on these ridiculous hours.

The second reason is not only were you there a lot, long hours, but I gather it was your practice or style of being a doctor that you were very open and approachable to the nurses, that is just your style of operating?

A. Yes.

Q. And in addition to those two things, I gather you were the ward chief in August of



1980, specifically from the 11th to the 22nd?

A. Correct.

Q. And that you were the ward chief in October?

A. Correct.

Q. And I gather then that you were consulted and you did consult with nurses on a regular basis and in particular with Carol Putherbough who was the clinical specialist at the time.

A. Well, I have known Carol for a long time. I saw her daily throughout her tenure at Sick Kids.

Q. And I gather that during this particular period she had many roles at the hospital, but during this particular period she was the clinical specialist in nursing, which was essentially not like other nurses there, she reported not to the head nurse but in fact had responsibilities to ensure good continuity of medical care, of medical and nursing care and as such reported to both nursing and medicine concerning parents and care of the children.

A. If you think my hours were long, they seemed short compared to Carol's.

Q. And I gather then during this period of time you would have had frequent conversations



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3 with her?

4 A. I would certainly see her
5 almost every day, I am not sure that on a daily basis
6 we would specifically discuss problems on the floor
7 of various patients, or parents, but just interfacing
8 in a social way.

9 Q. I understand your style of
10 operating was that you didn't necessarily sit down
11 and have formal meetings but that you were available
12 and free to be stopped in the hall and discuss a
13 problem, try and solve it and then move on.

14 A. I would think that is a fair
15 statement.

16 Q. And in your evidence to Ms.
17 Cronk I believe at Pages 5296 and 5297 you state that
18 it was your impression that there was, during this
19 period, the summer of 1980, a shortage of nurses in
20 Toronto, and a shortage of nurses at the Hospital for
21 Sick Children on this ward at night.

22 A. Correct.

23 Q. And I gather then that the basis
24 of your impression would be your own personal observa-
25 tions?

A. Correct.

Q. And would it be in conversations



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3 that you had with nurses?

4 A. I can't recall specifically
5 what factors led to that impression, whether it was --
6 certainly there was a striking difference, at least
7 as I perceived it, between the nursing complement on
8 days versus nights, and again whether it was from
9 talking to the nurses or my colleagues, but I had
10 that perspective, yes.

11 Q. The one difference of course is
12 that the head nurse works a straight day shift, not
13 nine to five, but those kind of hours Monday to
14 Friday?

15 A. Correct, and again often one
16 will see a number of student nurses on the floor
17 during the days where they are participating in patient
18 care that are not there at nights. I can't ---

19 Q. I guess whether they are a plus
20 or a minus as far as patient care is sometimes debated.

21 A. Well, again, I will leave that
22 to nursing to decide.

23 Q. Because I would like to explore
24 with you the basis of whether or not there was in fact
25 a shortage.

Dr. Freedom, you are aware that when
the ward moved from 5A to 4A/4B in April of 1980,



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there was, everyone has agreed, an increase of four infant beds.

A. Correct.

Q. And I gather that responding to that in April of 1980 there was a corresponding increase in the number of nurses.

A. I would presume with the increase in number of beds there should be a proportionate increase in number of nurses, yes.

Q. We understand there is a relatively mechanical system at the hospital called NARVEL which determines that if you have this many beds and this condition of the patients you get so many nurses.

A. I'm not familiar with that term, NARVEL, but I will take that as you state it.



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Q. So that the increase then
in the number of beds came in, in April of 1980,
increasing the number of nurses available on the
cardiology ward?

A. I would presume so, ideally.

Q. Now, the second aspect I
understand is that there was an increase in the number
of infant deaths?

A. Correct.

Q. And I gather that it was
decided that the nursing coverage on nights for
infants had to be roughly equivalent to the nursing
coverage on days, and that is because sick babies,
unlike children, need relatively constant nursing
care throughout a 24 hour period?

A. Yes, I would agree.

Q. Whereas when you put an eight
year old to bed, and hopefully he or she is going to
sleep the night and wake up in the morning?

A. Correct.

Q. But with the sick young babies
they require constant care throughout the night, just
as they did throughout the day?

A. Yes.

Q. And everyone has experienced
from personal observation that babies do not respect



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the clock sleeping when you would like to sleep?

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A. Correct.

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Q. Now I gather that because of

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the increase in the number of infant beds that a

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policy decision was taken to make the coverage on

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nights, that is the persons, the nurses giving

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patient care at night, roughly equivalent to the

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number of nurses giving patient care on days, that

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is direct patient care. Do you recall that in April
of 1980?

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A. Well again I don't recall any

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specific memorandum to me as one of the staff

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cardiologists addressing how nursing was going to be

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assigned to the floor. So again I will just take

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what you are saying, if that is a manual of operations
and how things happened I will take your comments.

16

Q. Well I am sure we will

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establish that through nursing then that in April of

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1980 there was an increase in the total complement

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of nurses for the ward. And secondly, that there was

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an increase in the coverage at nights. Now, then

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with respect to --

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THE COMMISSIONER: Did you agree with

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that that there was?

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THE WITNESS: I didn't get a chance

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to answer.



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MS. SYMES: Q. You said that --

THE COMMISSIONER: I am just wondering
was there an increase?

THE WITNESS: My perception was that
I saw less nurses at night than I saw during the day.

MS. SYMES: Q. And I will try to
explore with you the nurses that you didn't see at
night but that you saw in the days would have been
administrative nurses, such as the head nurse?

A. The administrative nurses, the
student nurses and the clinical teacher.

Q. I am going to come a little
bit more to the clinical teacher. With respect to
the nurses who were assigned to the direct patient
care, did you notice any difference between those
there on nights and those there on days?

A. Again I didn't come in to take
roll call, but when I would go onto the floor at night
I would have to look for a nurse; when I came in
during the day there were always nurses at the nursing
station and there just seemed to be more bodies. So,
as I said I certainly had the perception of a
difference between the day shift and the evening
shift. I would agree with you that if you asked me
to give you specific numbers I can't, it was just an
impression of that period of time.



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Q. In fact I think we do have the statistics with respect to the actual patient coverage and that there isn't that much of a difference between day and night, and would that surprise you?

A. It would surprise me because some several months ago when I had a conversation with Miss Ann Evans about this specific issue of nursing coverage, and she said yes, she remembered there was difficulty during that summer period with replacements.

Q. I was going to come to that, I am talking though between the nights and the days, I am going to come to that that you have just --

A. Well again I would be surprised, because again my visual perception, just like this morning I had the visual perception there were a lot of people in that audience and less so now, although I didn't do a head count.

Q. In the summer of 1980, as in every other summer, I gather that people go on holiday, specifically nurses go on holiday?

A. Well again I think, you know, we physicians will take some time off during the summer, so I presume the nurses will take it as well during the summer and throughout the year.



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Q. Dr. Freedom, is it possible that the shortage that you perceived was in fact the problem of trying to cover an increased number of nurses for 4A and 4B over the holiday period?

A. Would you mind if I closed the door, I am being distracted.

THE COMMISSIONER: No, I don't think it should be open in the first place.

THE WITNESS: Could you repeat that please?

MS. SYMES: Q. Is it possible that the perceived shortage that you saw of nurses during the summer period was due to the need to cover the vacation period for in fact a larger number of nurses?

A. I just can't address that. Again as I said my perception was there were fewer nurses at night, and I am not privy to the reason why there were or were not fewer nurses at night, whether it was holiday, illness, difficulties in getting nurses to the hospital, strikes, pay. So I can't tell you why they were not there.

Q. But your nurses are not unionized are they?

A. Well I guess not.

Q. They have never gone out on strike?



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A. Well I certainly don't want to insinuate that that is not true, I am just not privy as to why there would be a certain complement at one point in time and not at others.

Q. You certainly don't ever remember during this period a nursing strike, or any withholding of services?

A. By nursing, correct.

Q. Dr. Freedom, with the decision in April of 1980 to increase the coverage on nights because of the increased number of infant beds, do you recall that it was necessary to rearrange the schedule so that nurses worked proportionately more nights than they had in the past?

A. No, I don't recollect that.

Q. You don't remember receiving any complaints, especially from senior nurses, we now have to work fifty percent of our shift as night shift?

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A. Yes, I do remember them talking about working 12 and 12, but I can't, you know, twelve hours on and twelve hours off, but I can't remember in a time frame when I first heard that.

Q. Other than going to 12 hours, 12 hour shifts, do you recall any complaints about the fact that whereas they had to work, say, three weeks of days and two weeks of nights, they now were working 50/50, days and nights, a substantial increase in their eyes?

A. Again, all I recollect is what I just suggested, I do remember some comments about 12/12. I can't again put whether it was in comparison to the old way but, yes, this was the new way.

Q. Did you have any perception, first of all, did you have any observation that in the spring of 1980 and into the summer of 1980 that a number of senior nurses on that cardiac ward left, there was a staff turnover?

A. Well, certainly it has been my perception in the last number of years that nurses are turning over. I seem to see new faces every day. Again, because I am not the ward chief every month of the year I don't have a perception of who was there for three months and who is not, it just turned over.



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3 Q. Did you have a perception that
4 there were brand new nurses on the floor, that is,
5 people you hadn't seen before, starting in the summer
6 of 1980?

7 A. I think so but I just --

8 Q. Would you agree with me, Dr.
9 Freedom?

10 THE COMMISSIONER: Excuse me just a
11 moment, Ms. Symes. One of the great advantages of our
12 media coverage is it has been that it is not distracting.
13 I am afraid I find this present one distracting be-
14 cause it is making noise, and I don't want to spoil
15 the image of this being a public inquiry, but I
16 don't know whether it affects you but it affects me.

17 THE WITNESS: Yes, it does.

18 THE COMMISSIONER: And I think there-
19 fore I will have to ask you to -- I don't know
20 whether it is a question of technology or what it
21 is, but the other cameras don't, I don't even know
22 whether they are on or off, maybe they all went home
23 about three weeks ago for all I know.

24 This one I am afraid does and in
25 particular when you make a click and it doesn't effect
counsel so much but it does, I think, effect witnesses
and I can assure you it effects the Commissioner.



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So, if you don't mind. All right.
Now, Ms. Symes.

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MS. SYMES: I'm sorry, I was blocking it
out and trying to concentrate on your answers.

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Q. When nurses come new to your
cardiology ward, I gather that there is a period of
time in which they are trained, sometimes called
oriented, to learn the special procedures that you
require of your cardiology nurses?

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A. Yes, I understand that is correct.

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Q. How long in your observations
as a doctor on the ward does it take until you feel
comfortable that the nurse has mastered it?

A. I just don't have a clear feel-
ing because I think every nurse is different, every
nurse has previous experience and where she has been
is different, so I think it would vary from nurse to
nurse.

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Q. That is fair. You talked
about the teaching nurse, there was in fact a
teaching nurse assigned to 4-A/4-B and that was her
responsibility to train the nurses with respect to the
expectations on that ward?

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A. Yes.

Q. Now, in the summer of 1980 do you



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remember having conversations with the nurses as to the change or mix of the nurses who were now on the ward?

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A. Not specifically, no.

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Q. You have said at Page 5223 of the evidence, when you were reviewing the Monteith chart, and I think I can summarize it for you, that the Monteith record was reasonably good nursing notes but there is a difference in respect to what a physician looks for and what a nurse looks for.

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I would just like to explore the different roles that the two have in the care of the patient, which obviously is a common concern for both, would you agree?

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A. Yes.

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Q. Now, would you agree with me that the care provided to a patient on the cardiology ward depends upon the nurse making accurate observations of the patient?

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A. Of course.

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Q. Of recording those observations?

A. Yes.

Q. And of notifying the doctor if there are any changes?

A. Correct.

Q. And once the doctors receive that information either by reading the report or by hearing it from the nurse, then it is up to him or to her to make a decision as to what actions should be taken on those observations?

A. Yes, I would agree.

Q. And would you perhaps agree with me that the nurse, in fact, is in the best position to make those observations because she is there physically present on the ward in the room, say, unlike a doctor who comes in for short periods of time and then goes out?

A. Yes. I think there is basic truth to that. I think that often there may be some advantage to seeing a patient at different times during the day. It is like the example of a child who is living at home with his parents and is quite blue, they don't perceive the colour because they live with him every day. So, I think at times a difference a perception or perspective of a few hours may be



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helpful but I think all and all what you're saying about a nurse who is with the baby or a child will have certainly a very important perception on the management of that youngster.

Q. And would you agree with me that the person who is closely observing the child would be in the best position to note a change, that if the change in blueness, if there is a change in blueness or in pallor, as you have noted in other charts, that the nurse is certainly capable and trained to notice those changes.

A. Yes, again but I would say that at times if there is a very slow, subtle change, it may be helpful to have either a nurse or a physician to see that patient in two points in time separated by a point in time.

Q. Now, you have reviewed in preparation for coming to this inquiry, the charts on a great number of babies?

A. Correct.

Q. And you have also said that you've read the nursing notes, progress notes, looked at flow sheets with respect to the care that has been charted...

A. Correct.



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Q. ... as given to those babies?

A. Yes.

Q. For example, when we went through the Shrum baby, we looked at the flow sheets yesterday, we saw that the vital signs were taken every 15 to 30 minutes.

A. Correct.

Q. And would you agree with me that that is very close monitoring of a child?

A. Definitely.

Q. And that that was the appropriate level, that is, 15 to 30 minutes would be the appropriate level if the doctor ordered very close monitoring?

A. Yes.

Q. And would you agree with me that in general that the nursing notes that you saw were both detailed and accurate?

A. Yes.

Q. And that they fairly recorded what was happening to the baby?

A. I would have some slight concern of the way you worded that. I think that as far as the marriage between a doctor and a nurse and how they observe a patient, I can say that a baby's vital signs



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may be stable over an hour, that is, the respiratory rate, the heart rate, but yet, if a physician examines the child, there will be a different perception of gallop. So, when you say what is happening to the child, I take a little issue with that.

Q. I understand that nurses don't normally look for gallop rythmns.

A. Right.

Q. That's left for the doctor.

A. Correct. Therefore, I think there is a difference in perception between what a nurse will look for and i.c. have a perception of stability, whereas, a physician would have, perhaps, a different sense, based on his examination over the same period of time.

Q. I certainly don't quarrel with you. My question though is much simpler. In the reading of the charts is it your understanding or observation that the nurses accurately did what they were supposed to?

A. Yes.

Q. Right, okay. In other words, they didn't miss things that they should have seen?

A. That is my general feeling,



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definitely.

Q. So, when you read those charts, there is no astonishment that comes out to you, the nurse has missed important things that a nurse should have observed if a baby was deteriorating?

A. Correct.

Q. Okay. Now, you testified yesterday, two days ago, pardon me, in Volume 28, pages 5290 to 5295, just generally that in the latter part of the summer of 1980, you recalled that Carol Putherbough, who was the clinical specialist for cardiology, came to you to discuss the increasing deaths. You recollect, it is a bit foggy, I think you said, that the nurses were concerned about the number of babies dying on the ward. That is at page 5291, and the observation that the babies were dying at night, and that's 5295. Have I fairly stated your recollection?

A. Correct.

Q. I gather that you were first approached by Carol Putherbough, she was the first nurse that came to you?

A. Again, it is difficult for me to recollect which nurse came to me or whether it was Dr. Jedeikin or Dr. Rowe because I see Carol almost



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every day, I see Rowe, Jedeikin, every day and other nurses. So, I can't remember which specific individual -- I know Carol was there -- brought that to my attention, the attention of the whole group.

Q. I just want to explore what was brought to your particular attention. Do you recall Carol Putherbough coming to you and saying that she had been spoken to by a number of nurses concerning concerns that they had about the number of deaths on the ward; in other words, just to sum it up, that she was coming to you as a conduit between the nurses who had the actual care and the doctors who were in charge of the care?

A. No. As I said, I believe it was either yesterday or the day before, I certainly remember speaking to Carol but I couldn't place it whether it was before this first meeting or at the first meeting or subsequent to the first meeting and that hasn't changed.

Q. Well, her recollection of it, to put it fairly to you, was that it was before September 5th, 1980, that is, before the first meeting.

A. Well, you know, I have known Carol for a long time and, again, I just don't remember that.



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Q. Allright. I want to ask you what you understood were the concerns that the nurses had. I would like to go through each one. I gather that you understood, from what you said today, that they were concerned that there was a run on the number of deaths?

A. Correct.

Q. Those are the words that you used?

A. I don't believe I used the word run, I believe there was an increased number of deaths on the cardiac service.

Q. The concept I was trying to get across was whether it be a clustering or a string?

A. Or both.

Q. Or both. But that was a concern, wasn't it?

A. Yes, that there was an apparent increase in the number of deaths on the cardiac ward during the summer months.

Q. And that they were concerned it was a string of bad luck?

A. Again, I didn't have that perception of bad luck per se, it was just sick babies.

Q. All right. I'm asking you again



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what was brought to you as the nurses' concerns?

A. Again, I don't remember a specific conversation with nurses. I remember her speaking with Dr. Rowe about organizing the September 5th meeting or getting some of the charts available because of nursing concerns, you know, about the increased number of deaths. I sort of have that memory a little clearer than a specific nurse or Carol coming to me.

Q. Do you recall whether there was a concern, the concern expressed, that the deaths were now occurring on the wards as opposed to the Operating Room and the Intensive Care Unit, a new experience?

A. That was certainly voiced at that September meeting and, again, I think we took heedance because on the morning conferences we knew the children were dying on the floor.

Q. And that the deaths were at night, that you already said was one of the things brought to your attention?

A. Yes, correct.

Q. And was it also brought to your attention that it was occurring to the same nurses?

A. No.



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Q. That's not your recollection?

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A. It's not my recollection.

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Q. Is it possible that it was brought to your attention and you can't remember it?

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A. I guess it is possible. I think one of the features and I remember chatting with the police about this way back in '81 was that because we were on call every sixth or seventh night, are ward chiefs at different times, we don't get the perspective of the same nurses as we would during the course of the month. So, I knew it was a nighttime problem, I didn't have the opinion that it was a problem specific to a specific team.

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Q. Dr. Freedom, did you understand that the nurses had two concerns: No. 1, that they might be missing something which would have signified the decline in the baby and, No. 2, that perhaps they were not being most effective in the resuscitation efforts?

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A. No, I didn't have quite that Gestaltdt. I had a feeling from talking with Dr. Rowe that the nurses were concerned about the numbers of deaths and was there an obvious explanation for this and it wasn't clear whether it was resuscitation, or nursing of the patients. So, again, I can't put my



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finger on the things that you said. It was just a
feeling that the nurses were concerned about the
numbers of deaths.

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Q. I would like if you can, and
maybe it is not possible to try and separate out
what you heard from the nurses as opposed to what you
heard from Dr. Rowe?

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A. I just, you know, can't remember
specific conversations with specific individuals
during that period of time other than Dr. Rowe and
Jedeikin asking me to prepare or get these charts
together.

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Q. It is my information that these
conversations were before that?

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A. Well, it may be. I just don't
have any specific recollection of it.

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Q. Do you recall being asked by
Carol Putherbough if you would speak to the individual
members, the individual nurses who had experienced
the death to try and, with your knowledge of pathology,
give them a reason for death?

A. No, I don't have that specific
recollection. I knew that hopefully the focus of the
September meeting was to bring the nurses together
with the cardiologists to talk about the deaths that
we talked about.



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Q. Well, again, I'm trying to
talk before that September 5th meeting?

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A. I don't have any specific
recollection of Carol or other nurses coming to me
asking me to speak to them on an individual basis.

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Q. Do you have any recollection of
doing that before the September 5th meeting, of you
seeking out, not in a formal way, but seeking out the
nurses and explaining to them that this particular
baby who had died had severe anatomical problems and
there really was nothing that they could have done?

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A. Again, I don't have a specific
recollection but that has been my style ever since I
got into medicine to try to be as helpful to my staff
and nursing and it is certainly conceivable I may
have said something but I don't have a specific
recollection of doing that.

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Q. So, in the summer then of 1980,
you were aware that the nurses were concerned about
the deaths?

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A. I would say certainly towards the
end of the summer as I was getting ready to organize
with Dr. Rowe, not organize but to bring the material
together for the September 5th meeting - I was away
part of June and July if I recall.

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Q. But you were ward chief August
11th to 22nd?

A. Yes.

Q. So, you were there then?

A. Yes, but that is just eight or
nine days out of a summer.

THE COMMISSIONER: Miss Symes, I know
this may not be a convenient time but could we rise
now? What is your anticipation?

MS. SYMES: Yes, in fact that would be
fine.

THE COMMISSIONER: Yes. All right, we
will rise then until Monday at 10 o'clock.

--- Whereupon the Hearing adjourned until Monday,
September 12th, 1983, at the hour of 10:00 a.m.

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GOVT PUBNS

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